ESBT STRATEGIC COMMISSIONING BOARD

MONDAY, 2 OCTOBER 2017

2.00 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - East Sussex County Council Members

Councillor Keith Glazier (Chair)
Councillors David Elkin, Carl Maynard and Sylvia Tidy

Eastbourne, Hailsham and Seaford Clinical Commissioning Group and Hastings and Rother Clinical Commissioning Group Members

Dr Susan Rae, Hastings & Rother Clinical Commissioning Group
Dr Martin Writer, Eastbourne, Hailsham and Seaford CCG
Barbara Beaton, Hastings & Rother CCG
Julia Rudrum, Eastbourne Hailsham and Seaford CCG

A G E N D A

1 Minutes of the previous meeting *(Pages 3 - 6)*

2 Apologies for absence

3 Disclosure of Interests
Disclosure by all Members present of personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct and the CCGs' Conflicts of Interest Policy.

4 Urgent items
Notification of any items which the Chair considers urgent and proposes to take at the appropriate part of the agenda.

5 Questions from members of the public

6 East Sussex Better Together Financial Position and Progress with the Strategic Investment Plan *(Pages 7 - 10)*

7 East Sussex Better Together (ESBT) Alliance Outcomes Framework progress update *(Pages 11 - 26)*

8 East Sussex Better Together (ESBT) Alliance New Model of Care *(Pages 27 - 38)*

9 Collaborative Health and Wellbeing Stakeholder Group *(Pages 39 - 86)*

10 Work Programme *(Pages 87 - 90)*

11 Any other items previously notified under agenda item 4

PHILIP BAKER
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22 September 2017

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NOTE: As part of the ESBT Alliance's drive to increase accessibility to its public meetings, this meeting will be broadcast live on its website and the record archived for future viewing. The broadcast/record is accessible at
www.eastsussex.gov.uk/yourcouncil/webcasts/default.htm

ESBT STRATEGIC COMMISSIONING BOARD

MINUTES of a meeting of the ESBT Strategic Commissioning Board held at County Hall, Lewes on 6 June 2017

PRESENT:

Barbara Beaton (Chair) (Hastings and Rother CCG); Councillors David Elkin, Keith Glazier, Carl Maynard and Sylvia Tidy (all East Sussex County Council); Councillors Dr Martin Writer (Eastbourne, Hailsham and Seaford CCG) and Julia Rudrum (Eastbourne Hailsham and Seaford CCG)

WITNESSES:

East Sussex County Council

Keith Hinkley, Director of Adult Social Care and Health
Stuart Gallimore, Director of Children's Services
Cynthia Lyons, Acting Director of Public Health
Ian Gutsell, Head of Finance - ASC and Health
Bianca Byrne, Acting Head of Policy & Strategic Development

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG

Amanda Philpott, Chief Officer
Jessica Britton, Chief Operating Officer
John O'Sullivan, Chief Finance Officer

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

1 ELECTION OF CO-CHAIRS

1.1 The Board RESOLVED to nominate Cllr Keith Glazier and Barbara Beaton as co-chairs.

1.2 The Board RESOLVED to nominate Barbara Beaton as the Chair for the 6 June meeting.

2 APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Dr Susan Rae.

3 DISCLOSURE OF INTERESTS

3.1 Board Members made the following declarations of interest:

- Barbara Beaton declared personal interests as a Director and 100% owner of Sandpiper Business Support, and Director of Social Audit Network.

- Julia Rudrum declared a personal interest as a close relative of an employee of Sussex MSK Partnership.

- Dr Martin Writer declared personal interest as a GP whose GP practice provides a community dermatology service, and intermediary care services for two intermediary care homes in Eastbourne.

4 URGENT ITEMS

4.1 There were no urgent items.

5 TERMS OF REFERENCE

5.1 The Board considered a report setting out its terms of reference.

5.2 The Board RESOLVED to note the terms of reference.

6 PROCEDURE RULES

6.1 The Board considered a report setting out its procedure rules.

6.2 The Board RESOLVED to agree the procedure rules.

7 OVERVIEW OF HEALTH AND CARE NEEDS

7.1 The Board considered a report providing an overview of health and care needs in the East Sussex Better Together (ESBT) area, and the proposed outcomes for the ESBT Alliance.

7.2 The Board RESOLVED to:

1) note the East Sussex Better Together Health and Care Needs Summary Report;

2) agree the high level outcomes and revised associated targets for inclusion in the East Sussex Better Together Alliance Outcomes Framework.

8 PROPOSED STAKEHOLDER AND CITIZEN GOVERNANCE ARRANGEMENTS

8.1 The Board considered a report setting out proposed plans for citizen and stakeholder engagement in the ESBT Alliance strategic planning and governance arrangements.

8.2 In response to a query from the Board, the Chief Finance Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG), clarified that many of the existing patient participation groups and partnership boards are keen to merge into the Health and Wellbeing Council as it would be

more representative of the integrated health and social care service that is now being provided in the ESBT area. However, certain stakeholder groups will be retained where it makes sense to do so, for example, the Learning Disability and Autism Partnership Board will be retained to fulfil statutory obligations.

8.3 The Chair said that it was important to ensure that residents in the ESBT area were involved at every level of the development and provision of services. The Board agreed that these governance arrangements would need to be kept under review to ensure that they were effective in practice.

8.4 The Board RESOLVED to:

1) Agree the proposal to launch a new collaborative stakeholder representative 'Health and Wellbeing Council' as the key mechanism to support citizen and stakeholder engagement in the strategic planning process;

2) Agree that a representative(s) from the new 'Health and Wellbeing Council' is invited to sit on the Strategic Commissioning Board; and

3) Agree to establish a single health and wellbeing provider forum to engage voluntary and independent care sector service providers in strategic planning and market development.

9 ESBT ALLIANCE OUTCOMES FRAMEWORK

9.1 The Board considered a report providing an update on the progress on developing the ESBT Alliance Outcomes Framework, and seeking agreement to adopt the Framework as a pilot.

9.2 The Board welcomed the Outcomes Framework. Cllr Glazier commented that a measure of success for the ESBT Alliance would be when residents began to see improved health and wellbeing. Dr Martin Writer added that a measure of its success would be if people no longer felt the need to talk about issues and deficiencies with health and social care and instead simply received the care that they needed.

9.3 The Chair said that it was important the Outcomes Framework did not just report on financial outcomes but tangible benefits for residents as well. The Chair considered that the Board would need to take a robust 'critical friend' approach towards the ESBT Alliance.

9.4 The Board RESOLVED to:

1) note progress made towards establishing the pilot ESBT Alliance Outcomes Framework; and

2) agree and adopt the pilot Outcomes Framework to further test and refine during the test-bed year

10 ESBT STRATEGIC INVESTMENT PLAN (SIP)

10.1 The Board considered a report providing a summary of the ESBT Strategic Investment Plan (SIP) for 2017/18.

10.2 Julia Rudrum explained that it was important that the Board fulfils its role of providing oversight of the SIP during the 2017/18 financial year. The Chair said that the Board will need to monitor the progress of the SIP in some detail at future meetings.

10.3 Dr Martin Writer said that the commencement of the SIP in April 2017 indicated the success of the ESBT programme to date. Going forward the ESBT Alliance will be delivering more effective care as a partnership with a combined set of values, and the partners need to be optimistic and pragmatic about the task ahead.

10.4 The Board RESOLVED to note the report.

The meeting ended at 2.31 pm.

Barbara Beaton
Chair

Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of meeting:	**2 October 2017**
By:	**Director of Adult Social Care and Health, East Sussex County Council; and Chief Officer, Eastbourne Hailsham & Seaford and Hastings & Rother Clinical Commissioning Groups**
Title:	**East Sussex Better Together Financial Position and Progress with the Strategic Investment Plan**
Purpose:	**To provide the ESBT Strategic Commissioning Board with an update on the ESBT financial position and progress with the Strategic Investment Plan**

RECOMMENDATIONS

The Board is recommended to note the update on the East Sussex Better Together financial position and progress with the Strategic Investment Plan.

1. Background Information

1.1 East Sussex Better Together (ESBT) is the whole system health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population. Originally formed as a partnership between Eastbourne, Hailsham & Seaford (EHS) Clinical Commissioning Group (CCG), Hastings and Rother (H&R) CCG and East Sussex County Council, the Programme now formally includes East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT). Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes.

1.2 The partnership is moving to the next phase of the work to fully integrate and embed into core business the commissioning and delivery of health and social care. The Council and CCGs have agreed to align the respective budgets for Adult Social Care, Public Health, relevant parts of Children's Services with those for Clinical Commissioning, as part of the transition to the ESBT accountable care model which is intended to take a whole-systems approach to the planning and delivery of health and social care across the ESBT area. The aligned budgets have been drawn together into a Strategic Investment Plan (SIP) which was presented in summary form for 2017/18 at the last meeting of the Strategic Commissioning Board. The SIP is a medium term plan covering the period to 2020/21 which following further development with ESBT partners can now be considered for agreement.

1.3 Below is the summary of partners' investment in the SIP:

East Sussex Better Together Strategic Investment Plan	**2017/18 £'000**
Adult Social Care Base Budget	127,604
Council Tax Additional 1% Precept	1,887
Adult Social Care Base Budget	**129,491**
Supporting Adult Social Care Grant (one-off for 2017/18)	2,000
Improved Better Care Fund	220
Additional Adult Social Care Funding (Spring Budget)	8,491
Total Adult Social Care	**140,202**
Public Health	19,313
Children's Services	5,505
Total ESCC Investment in the ESBT SIP	**165,020**
Eastbourne Hailsham & Seaford CCG	341,638
Hastings & Rother CCG	355,753
Total ESBT SIP Investment	**862,411**

2 Supporting Information

2.1 The vision of ESBT is to meet population health need by delivering fully integrated and sustainable health and social care. The SIP sets out a medium term financial plan that enables the Council and CCGs to set balanced budgets for 2017/18 by identifying £39.9m of delivery challenge in 2017/18 and creates a sustainable system that promotes health and wellbeing whilst addressing quality and safety issues, in order to achieve the following triple aims:

- Prevent ill health and deliver improved outcomes for our population
- Enhance the quality and experience of care people receive; and
- Ensure the future affordability and sustainability of services.

2.2 Detailed monitoring of each scheme shows that the SIP programme is currently behind plan in terms of delivery and impact. Specifically the demand mitigation and diversion from acute settings that the SIP seeks to achieve have yet to be achieved at the scale required. This is reflected in the position of the ESBT contract and the year to date financial position.

2.3 An integrated financial monitoring process has been put in place which includes ESHT as well as ESCC and the CCGs. Significant budget variations apparent in the financial monitoring at Month 4 are as follows:

Budget Heading	Variation, £M	Adverse or Favourable
CCG spending on Acute	+12.8	ADV
CCG spending on Primary	-1.3	FAV
Adult Social Care	+0.5	ADV
Other CCG	-0.6	FAV
CCG use of reserves	-10.8	FAV
Net	**+0.6**	**ADV**

2.4 At Month 4 position there is a year to date adverse position (overspend) of £0.6m. The year to date position shows the pressure on the system, with a reliance on use of reserves as the major balancing item in the current position. All the CCG reserves have been applied in the M4 position and cannot therefore be relied upon for further mitigation. Spending at current levels is not sustainable and, if no corrective action is taken, the health and care system will be significantly out of financial balance.

2.5 A detailed plan is being developed to set out the action needed to achieve financial balance across the system. This includes a full review of the existing SIP schemes to ensure that the system maximises the benefit of existing schemes and investment needed to achieve this.

2.6 Currently there are nine projects RAG rated as being either red or amber on delivery. The factors contributing to the current overall position in performance are:

- Project slippage – falling behind predicted implementation milestones either through supplier issues or difficulties recruiting sufficient staff.
- Uptake – some project require further engagement with clinicians to ensure the appropriate changes in the pattern of service use. This has led to adjustments being made to the service model

2.7 In relation to the nine red or amber rated projects, a number of actions have been agreed via the Alliance Executive to improve performance and reduce current risks identified. These include:

- **Technology Enabled Care Services (TECs)** – the rollout of this project has been significantly hampered by contractual issues with the provider. A decision has been made to postpone any further expansion of the existing scheme until the contract dispute has been resolved. This means both the savings and investments for the scheme will need to be removed from the SIP. Any net loss of this is believed will be more than offset by a natural expansion in patients numbers already be realised within the baseline scheme.
- **Falls and Fracture Liaison** – initial recruitment issues have delayed implementation. An adjustment to the service model has helped overcome the issue. Locum staff have now been employed to increase capacity in the service offset some of the slippage and improve levels of planned savings.

- **Care Home Plus** – the rollout of this programme remains difficult as a result of available care home beds. This has been further hindered by the loss of 6 beds following CQC inspections, however 20 further beds have been identified by ESCC and they are rapidly exploring how these are be utilised.
- **Integrated Support Workers** – the initial plan to recruit 100 staff by April 2017 was revised following initial difficulties recruiting staff. There is now slippage on the revised recruitment trajectory, although constant efforts to recruit new staff are being made. A further plan to expand and build community capacity is being developed aimed at reducing the pressure on current recruitment and diversifying the workforce.
- **Proactive Care** –a comprehensive programme to increase awareness amongst patients and clinicians has been undertaken as well as a change to the service model to include referrals for newly diagnosed type 2 diabetic patients to support self-management. Whilst these changes are relatively recent early indications are that referrals in Month 4 have significantly increased.
- **Crisis Response –** the anticipated impact of the service has been reduced by initially low referral rates and a shortage in home care providers to hand patients over to. An extensive programme of promoting the service within primary care and with the ambulance service has been undertaken and integrated home care capacity has been increased. These have helped increase referrals to the service but their impact has been use of the service for the Discharge to Assess Programme which was not envisaged within original planning.
- **Frailty Practitioners –** like Crisis Response the impact of Frailty Practitioners has been reduced by their increased focus on the discharge to assess programme, which has supported early discharge and improvements in A&E performance but reduced capacity for admission avoidance.
- **Back Office Services** - A significant risk to this scheme has been identified and mitigating action is being coordinated by ESBT Finance Group.
- **Locality Planning** - £9m of savings have been attributed to the impact of establishing Locality forums and plans to enhance service delivery at a local level. Plans are on-track for these to be established and working by October 2017.

3 Conclusion and reasons for recommendations

3.1 The ESBT Strategic Commissioning Board is recommended to note the update on the East Sussex Better Together financial position and progress with the Strategic Investment Plan.

AMANDA PHILPOTT
Chief Officer

KEITH HINKLEY
Director of Adult Social Care and Health

Contact Officers:

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Keith Hinkley, Director of Adult Social Care and Health , East Sussex County Council Tel: 01273 481288

Background documents:

None

Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of meeting:	**2 October 2017**
By:	**Director of Adult Social Care and Health, East Sussex County Council; and Chief Officer, Eastbourne Hailsham & Seaford and Hastings & Rother Clinical Commissioning Groups**
Title:	**East Sussex Better Together (ESBT) Alliance Outcomes Framework progress update**
Purpose:	**To provide the ESBT Strategic Commissioning Board with an update on progress with development of the ESBT Alliance Outcomes Framework and a sample of performance data for the first quarter of 2017/18**

RECOMMENDATIONS

The ESBT Strategic Commissioning Board is recommended to note progress made with further developing and refining the pilot ESBT Alliance Outcomes Framework, including:

- **Finalising baselines, targets and trajectories for each performance measure;**
- **Developing quarterly reporting arrangements;**
- **Sample trends and direction for Quarter 1 in Appendix 2; and**
- **Further plans for engagement and co-design, including the production of publically accessible performance information.**

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1. Background

1.1 The 2017/18 test-bed year for the formal ESBT Alliance is designed to enable oversight of the whole health and care system from both a commissioning and delivery perspective, supporting us to act collectively in a way that delivers improvements for our local population. Building on our original ESBT work on reporting progress against population health and health inequalities outcomes it has been agreed that for this test-bed year, we need a small group of shared system-wide priority outcomes which we can work towards and further test and refine during the year. Although at a developmental stage, ultimately it is envisaged that this will:

- Enable us to understand if our ESBT Alliance arrangement is working effectively to deliver improvements to population health and wellbeing; experience and quality, and sustainability;
- Enable commissioners, providers and staff working in the system to recognise and use the same outcomes framework to guide their work with patients, clients and carers, and see how their activity or part of the care pathway contributes to delivering the outcomes that are meaningful for local people; and
- Complement the way the ESBT Alliance uses our collective business intelligence to understand the performance of the health and care system as a whole.

1.2 At the ESBT Strategic Commissioning Board meeting on 6 June 2017, a draft outcomes framework with key indicators and performance measures organised within four key outcome domains was agreed as a pilot during 2017/18. The pilot integrated framework and measures is included at Appendix 1 for ease of reference.

1.3 The need for an integrated Outcomes Framework to measure performance of our whole ESBT health and care system is further highlighted as a result of the plans agreed by the ESBT Alliance partners in July 2017 for formal integration by 2020/21, initially through strengthening the Alliance arrangement for April 2018. This will mean putting in place single leadership and performance management of our commissioning resource, as well as moving towards single leadership of how we organise delivery of our services (the subject of a separate report to the ESBT Strategic Commissioning Board).

1.4 As we move towards developing the detailed business case for an integrated health and care organisation by 2020/21, our Alliance Outcomes Framework will also need to take account of the national incentive framework that is in development as part of the standard Accountable Care Organisation Contract for procuring new care models.

2. Pilot ESBT Alliance Outcomes Framework progress

2.1 Since the pilot ESBT Alliance Outcomes Framework was agreed on 6 June 2017, work has continued to develop and refine the framework and finalise baselines, targets and trajectories for each performance measure. Targets are being established for a five year period from 2016-2021 to align with the Strategic Investment Plan (SIP) planning horizon. This will be subject to adjustment according to the future contractual model agreed for Alliance provision, and the learning generated in the pilot period.

2.2 Data sources have been identified for the majority of measures and it is anticipated this will be completed by the end of October. Work is also ongoing to establish targets for the more developmental measures in the framework; however we may not be in a position to set targets for some measures until the end of the current financial year to inform next year's outcomes progress. These are as follows:

- Increase people accessing the support available to them in their local communities
- Waiting time to initiation for home care packages
- Proportion of people who have access to active care coordination
- Activation levels of people receiving services
- Increase in people reporting being treated with care, kindness and compassion

2.3 A small number of additional measures have been proposed to reflect priorities across the system and support measurement of improvements across the system. These will be considered for inclusion in the next iteration of the Outcomes Framework at the end of the pilot year and include:

- Improving mental health of parents
- Identification of carers in primary care
- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their long-term conditions.

2.4 Dialogue is also taking place with lead commissioners across our health and care system to align future commissioning activity with the four domains within the draft outcomes framework.

2.5 In line with finalising baselines, targets and trajectories for each performance measure, we are also in the process of drawing together quantitative performance data, where available, for each domain. A sample of performance for the first quarter showing trends and the direction of travel for two measures within each domain is included at Appendix 2. In summary:

- Breastfeeding rates have fluctuated between 2012/13 and 2016/17. Rates were highest in 2012/13 (46%) and dropped to their lowest in 2015/16 (41%), whilst 2016/17 saw an increase again (44%).
- Maternal smoking rates for the ESBT area have reduced, however they remain worse than England for each of the last four years.
- The proportion of adults with learning disabilities in paid employment is increasing and is above the national average.
- The proportion of people 65+ who are still at home three months after a period of rehabilitation is increasing and is above the national average.
- The average length of stay has steadily remained under 8 days since 2014 and in Quarter 1 (2017/18) the average rate has decreased further to its lowest rate (7.20).
- The number of non-elective admissions has decreased since 2014 and this trend seems to have continued in Quarter 1.
- The total number of infections in Eastbourne, Hailsham and Seaford increased in by 43 cases between 2015/16 and 2016/17 whilst in Hasting and Rother these have decreased by 27.
- Using the ESSC methodology of data capturing, there has been a uniform trend in the number of falls since 2014 which have ranged between 2332-2330.

2.6 To support monitoring an oversight of the system we plan to produce quarterly highlight reports to show performance across the system. These will be supported by a one-page summary in an infographic format to present the information to the public and other stakeholders. A full report showing performance against targets will also be produced at the end of each year, and will include both quantitative and qualitative data. Within this we will need to manage the challenges of variations in reporting frequencies and the ongoing development of data at an ESBT level.

2.7 The quantitative data in the outcomes framework will be enhanced by qualitative data in the form of case studies and survey data collected through the ESBT Public Reference Forum[1].

3. Engagement with local people

3.1 Following on from engagement in April and May 2017, we will continue to engage with local people during 2017/18 to further inform and shape the Alliance Outcomes Framework and test the pilot outcome measures. Follow up sessions will be held with the Patient Participation Group Forums and at Shaping Health and Care events in the coming weeks and months.

3.2 A range of accessible materials are being produced to introduce the pilot outcomes framework to the public and other stakeholders:

- The outcomes framework overview document can be seen at Appendix 1.
- A one-page infographic has been designed to introduce the framework to the public in an accessible format (see Appendix 3). Further infographics will be produced highlighting areas of progress each quarter and some areas to improve in the next quarter.
- A two-minute introductory video is planned to explain the outcomes framework in simple terms. This will be available by December.

The Public Reference Forum is managed by East Sussex Community Voice and has the following strategic outcomes:

1. [1] Local people are able to engage and participate in the aims, objectives and workstreams of the East Sussex Better Together Alliance; particularly those less likely to be heard and/or those from protected characteristic communities.
2. East Sussex Better Together Alliance is informed and shaped by local people and its progress and success is measured by local people taking part in the Public Reference Forum.

- Dedicated web pages on the ESBT website will contain an introduction to the outcomes framework, relevant background documentation, quarterly reports and qualitative case studies. The design can be seen at Appendix 4. The page will be available by the end of October and will include an interactive version of the Outcomes Framework with each of the four domains containing the following information for the public to navigate:
    - Introduction
    - List of measures and performance summary document
    - Latest quarterly infographic
    - Relevant case study (after Quarter 3)

4. Next steps

4.1 Work will continue to establish baseline figures and set targets for the five year period. As reporting processes become established, more detailed highlight reports will be available from Quarter 2 onwards. It is proposed that reporting will be quarterly in arrears to allow for data availability.

4.2 Alongside this we will be testing the overall approach and public-facing materials with the public and stakeholders to make sure the pilot outcome measures are the right ones, and that we are communicating our aims and progress clearly.

4.3 We will continue working with lead commissioners to align commissioning activity with the four domains within the draft outcomes framework.

5. Conclusion and reasons for recommendations

5.1 Research and discussions about our new model of accountable care continue to highlight the need for an integrated outcomes framework which to measure improvements on a system-wide basis and test how well our whole health and care system is working.

5.2 The pilot framework has been well-received and will be used to inform our stakeholders about progress made by our ESBT Alliance against our health and care system priorities to deliver improvements to population health and wellbeing, experience, quality and sustainability – including the per capita cost of care.

5.3 Further development of our pilot integrated Outcomes Framework is needed to prepare for the move towards single leadership and performance management of our commissioning resource and strengthened governance by April 2018, as well as the move towards single leadership of how delivery of our Alliance services are organised. An integrated whole health and care system Outcomes Framework will be crucial to ensure oversight of system performance against investment made.

5.4 The ESBT Strategic Commissioning Board is asked to note progress made with further developing and refining the pilot ESBT Alliance Outcomes Framework, including:

- Finalising baselines, targets and trajectories for each performance measure;
- Developing quarterly reporting arrangements;
- Sample trends and direction for Quarter 1 in Appendix 2; and
- Further plans for engagement and co-design, including the production of publically accessible performance information.

KEITH HINKLEY
Director of Adult Social Care and Health, ESCC

AMANDA PHILPOTT
Chief Officer, EHS and HR CCGs

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BACKGROUND DOCUMENTS
None

Appendix 1: Draft outcomes framework overview

Outcomes Framework

The ESBT Alliance Outcomes Framework shows our commitment to measuring our progress against the health and care priorities that matter to you. For local people using our services in the new ESBT Alliance, that means a way to measure whether the services they receive (activities) will improve their health, well-being and experience of care and support (outcomes). Overall we want to improve the health and wellbeing of our population, the quality and experience of health and care services, and keep this affordable.

The measures and key indicators in this document have been chosen because they are what people have told us is important to them, and will give us a good indication of overall system performance. The ESBT Alliance Outcomes Framework complements the existing Outcomes and Performance Frameworks that the individual ESBT organisations work to for Adult Social Care, Public Health and the NHS, and is designed to provide an overview of how well we are performing together as a system.

Population health and wellbeing

We want to improve health and wellbeing for local people

Outcomes	These indicators and measures will tell us how we are doing...	
Children are supported to have a healthy start in life	The proportion of babies who were fully or partially breastfed	Increase in percentage of babies aged 6-8 weeks who were fully or partially breastfed
	The rate of obesity among children	Reduction in excess weight in children aged 4-5 years Reduction in excess weight in children aged 10-11 years
	The proportion of mothers known to be smokers at the time of delivery	Reduction in percentage of mother known to be smokers at the time of delivery
People are supported to have a good quality of life	The proportion of people reporting a good quality of life	Improve health-related quality of life for older people Improve social-care-related quality of life for adults Increase in number of people who feel they have enough social contact
	The rate of overall mental wellbeing	Increase in proportion of people who say they are not anxious or depressed Decrease in attendances at A&E for self-harm per 100,000 of local population
People are supported to live in good health	The average number of years a person would expect to live in good health	Healthy life expectancy at birth for men Healthy life expectancy at birth for women
	The rate of preventable deaths	Reduction in preventable mortality Reduction in mortality amenable to healthcare

We want to reduce health inequalities for local people

Inequalities in healthy life expectancy are reduced	The gap in rates of obesity in children between the most and least deprived areas	Reduction in the gap in excess weight of 4-5 year olds between the most and least deprived areas Reduction in the gap in excess weight of 10-11 year olds between the most and least deprived areas
	The gap in health related quality of life for older people between the most and least deprived areas	Reduction in the gap in health-related quality of life for older people between the most and least deprived areas
	The gap in rates of preventable deaths between the most and least deprived areas	Reduction in the gap in preventable mortality between the most and least deprived areas Reduction in the gap in mortality amenable to healthcare between the most and least deprived areas

The experience of local people

We want to put people in control of their health and care

Outcomes	These indicators and measures will tell us how we are doing...	
People and their carers feel respected and able to make informed choices about services	The proportion of people using services who feel they have been involved in making decisions about their support	Ensure people using services receive self-directed support People receiving services feel they have enough choice over their care and support services People receiving services feel they have as much control as they want over their daily life
	The proportion of carers who feel they have been involved in decisions about services	Carers feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care for Carers feel that their needs as a carer were taken into account in planning their support
People and their carers have choice and control over services and how they are delivered	The number of people in receipt of direct payments for their care or personal heath budgets	Increase in the number of people using services who receive direct payments for their care Increase the number of people in receipt of personal health budgets
	The number of carers in receipt of direct payments	Increase in the number of carers using services who receive direct payments

We want good communication and access to information for local people

People can find jargon free health and care information in a range of locations and formats	The proportion of people and carers reporting they find it easy to access and use information about services	People find it easy to find information and advice about support, services or benefits. Carers find it easy to find information and advice about support, services or benefits
Health and care services talk to each other so that people receive seamless services	The proportion of people and carers reporting they have only had to tell their story once	People who contact us about their support have not had to keep repeating their story Carers who contact us about support have not had to keep repeating their story

We want to deliver services that meet people's needs and support their independence

People are supported to be as independent as possible	The number of people living at home and accessing support in their communities	Increase in people accessing the support available to them in their local communities Fewer people are permanently admitted to residential and nursing care homes
	The proportion of people with support needs who are in paid employment	Increase in the proportion of adults with learning disabilities in paid employment Increase in proportion of adults in contact with secondary mental health services in paid employment
	The proportion of people who regain their independence after using services	Proportion of people 65+ who are still at home three months after a period of rehabilitation Proportion of people needing less acute, or no ongoing, support after using short-term services
People are supported to feel safe	The proportion of people and carers who report feeling safe	People feel as safe as they want People feel care and support services help them feel safe Carers feel safe and have no worries about their personal safety

Transforming services for sustainability

We want to demonstrate financial and system sustainability

Outcomes	These indicators and measures will tell us how we are doing...		
People have access to timely and responsive care	The waiting times for primary care GP services and community support and care services	⇨	Waiting time to get a GP appointment Waiting time to initiation for home care packages
	The referral times for health treatment	⇨	Constitutional NHS standards are met Increase in proportion of people referred with first episode of psychosis who are seen within 2 weeks
	The length of stay in hospital	⇨	Reduction in length of stay in hospital for identified cohort Reduction in delayed transfer of care out of hospital
People access acute hospital services only when they need to	The number of people accessing hospital in an unplanned way	⇨	Reduction in number of A&E attendances Reduction in number of non-elective admissions Reduction in emergency admissions for chronic ambulatory care sensitive conditions
Financial balance is achieved across the system	The average Year of Care Costs	⇨	Reduction in average Year of Care Costs

We want to deliver joined up information technology

People and staff working within the system have access to shared and integrated electronic information	The proportion of people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system	⇨	Proportion of systems feeding in to the integrated personal record Proportion of systems feeding in the integrated reporting system Proportion of systems feeing in to the citizen record

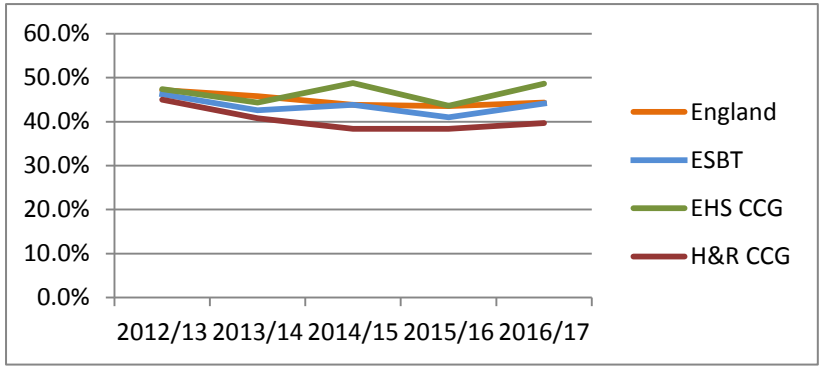
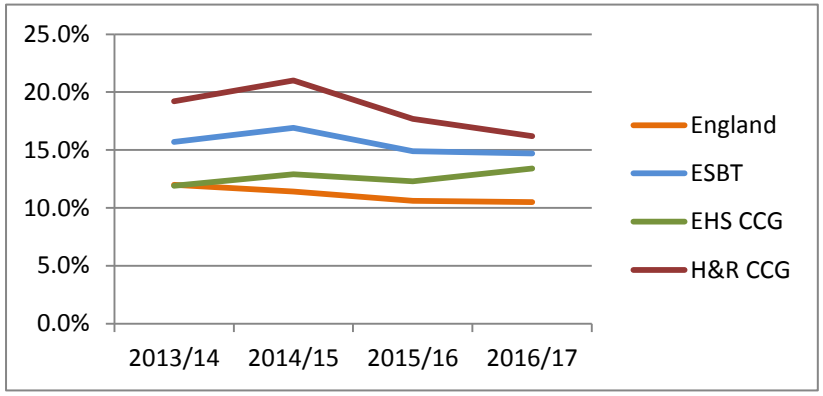
We want to prioritise prevention, early intervention, self care and self management

Interventions take place early to tackle emerging problems, or to support people in the local population who are most at risk	The flow of investment from acute hospital services to preventative, primary GP, and community health and care services	⇨	Increase the proportion of funding invested in preventative, primary and community provision
	The proportion of services developed to intervene proactively to support people before their needs increase	⇨	Activation levels of people receiving services Number of people being screened for frailty Number of people who have a care plan from a proactive service Proportion of people accessing services through case finding Proportion of people who have access to active care coordination

Quality care and support

Outcomes	These indicators and measures will tell us how we are doing...	
We want to provide safe, effective and high quality care and support		
People are supported by high quality care and support	The proportion of people reporting satisfaction with the services they have received	Increase in number of people who report they are satisfied with the care and support they receive Increase in number of carers who report they are satisfied with the care and support they receive Increase in number of people reporting being treated with care, kindness and compassion Increase in proportion of bereaved carers reporting good quality of care in the last three months of life
	The effectiveness of the health and care intervention the person has received	Improve the health gain people experience after elective procedures Increase in number of older people still at home 91 days after discharge from hospital
People are kept safe and free from avoidable harm	The number of healthcare-related infections and serious incidents	Reduction in healthcare-related infections Reduction in number of serious incidents in healthcare
	The effectiveness of the safeguarding enquiry	Increase in the number of adults who were asked what their desired outcomes of the safeguarding enquiry are, and of those how many were fully/partially achieved
	The number of falls in the population of local people	Reduction in the number of falls in East Sussex
We want to deliver person centred care through integrated and skilled service provision		
People and their families are engaged in the settings of their outcomes and the management of their care	The proportion of people involved in setting the outcomes they want to achieve from their health and care services	Increase in proportion of people using services who are involved in determining the outcomes that are most important to them Increase in percentage of patients self-reporting improved outcomes in their general health following the elective procedure
People are supported by skilled staff, delivering person-centred care	The levels of staff satisfaction	Increase in staff satisfaction levels Reduction in staff turnover
	The proportion of staff who have received training in person-centred care	Increase in percentage of staff who have completed at least 80% of their mandated training Increase in proportion of staff who have the Care Certificate Increase in staff who have completed person-centred care and support planning training

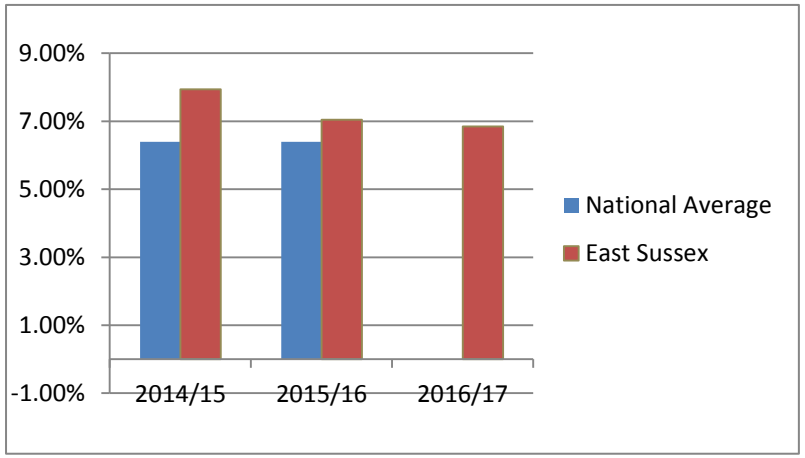
Appendix 2: Quarter 1 performance data from a sample of performance measures for each domain

Domain	Outcome	Performance measure	Performance
Population health and wellbeing	Children are supported to have a healthy start in life	Increase in the percentage of babies aged 6-8 weeks that were fully or partially breastfed **Definition:** Percentage of all infants due a 6-8 week check that are totally or partially breastfed.	
		Reduction in the percentage of mothers known to be smokers at the time of delivery **Definition:** Percentage of women known to be smokers at the time of delivery.	

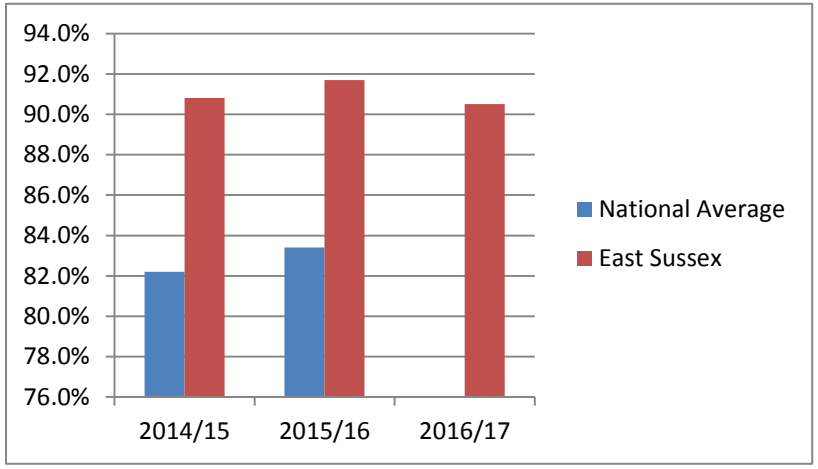
	2012/13	2013/14	2014/15	2015/16	2016/17	Q1 (2017/18)
England	47.2%	45.8%	43.8%	43.5%	44.3%	
ESBT	46.2%	42.6%	43.8%	41.0%	44.1%	42.50%
EHS CCG	47.4%	44.3%	48.8%	43.6%	48.6%	45.00%
H&R CCG	45.0%	40.8%	38.4%	38.4%	39.7%	39.80%

	2013/14	2014/15	2015/16	2016/17	Q1 (2017/18)
England	12.0%	11.4%	10.6%	10.5%	
ESBT	15.7%	16.9%	14.9%	14.7%	14.9%
EHS CCG	11.9%	12.9%	12.3%	13.4%	9.5%
H&R CCG	19.2%	21.0%	17.7%	16.2%	16.0%

<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">The experience of local people</td><td>The proportion of people with support needs who are in paid employment</td><td>Increase in the proportion of adults with learning disabilities in paid employment

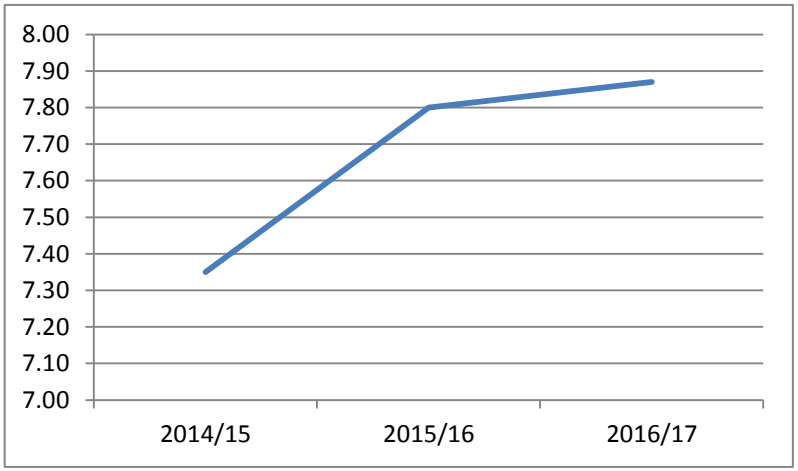
Definition: The proportion of working age adults with a Primary Support Reason (PSR) of Learning Disabilities who are known to the council, who are recorded as being in paid employment within the financial year.</td><td> 

<table>
<tr><th></th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>National Average</td><td>6.40%</td><td>6.40%</td><td></td><td></td></tr>
<tr><td>East Sussex</td><td>7.94%</td><td>7.05%</td><td>6.85%</td><td>6.94%</td></tr>
</table></td></tr>
<tr><td>The proportion of people who regain their independence after using services</td><td>Proportion of people 65+ who are still at home three months after a period of rehabilitation

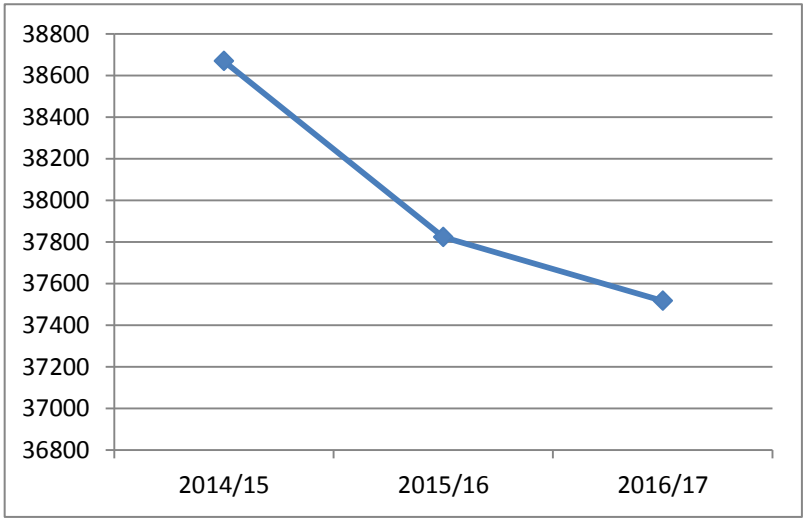
Definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on/back to their own home who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge from hospital.</td><td> 

<table>
<tr><th></th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>National Average</td><td>82.2%</td><td>83.4%</td><td></td><td></td></tr>
<tr><td>East Sussex</td><td>90.8%</td><td>91.7%</td><td>90.5%</td><td>94.6%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">Transforming services for sustainability</td><td>The length of stay in hospital</td><td>Reduction in length of stay for identified cohort

Data source: Data extracted from Secondary Uses Service (SUS inpatient data based on discharge date and admission method being an Emergency Admission. As a mean Length of Stay (LoS) can be disproportionately affected by small numbers of outlier values a truncated mean is shown, which excludes the top 10% of values.</td><td> 

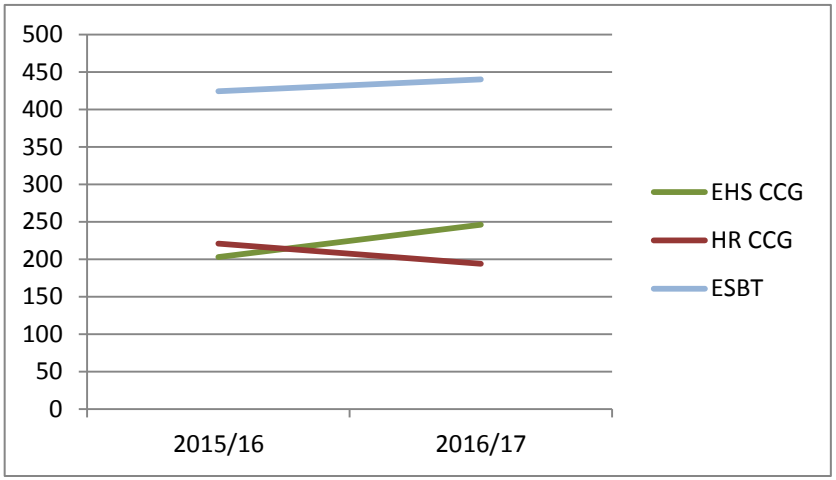
<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No. of days</td><td>7.35</td><td>7.80</td><td>7.87</td><td>7.20</td></tr>
</table></td></tr>
<tr><td>The number of people accessing hospital in a planned way</td><td>Reduction in the number of non-elective admissions

Data source: Extracted from SUS inpatient data based on discharge date and an admission method recorded as emergency admission methods, including through an Emergency Care Department and via a General Practitioner</td><td> 

<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No. of people</td><td>38,669</td><td>37,823</td><td>37,517</td><td>9,342</td></tr>
</table></td></tr>
</table>

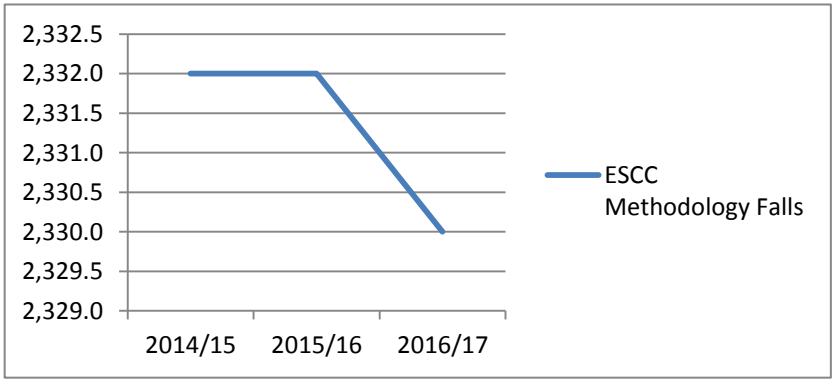
<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">Quality care and support</td><td>The number of healthcare-related infections and serious incidents</td><td>Reduction in healthcare related infections

Data Source: Public Health England Data Capture System

Definition: The infections being captured are: e.coli Bacteraemia, Clostridium Difficile and MRSA Bacteraemia.</td><td> 

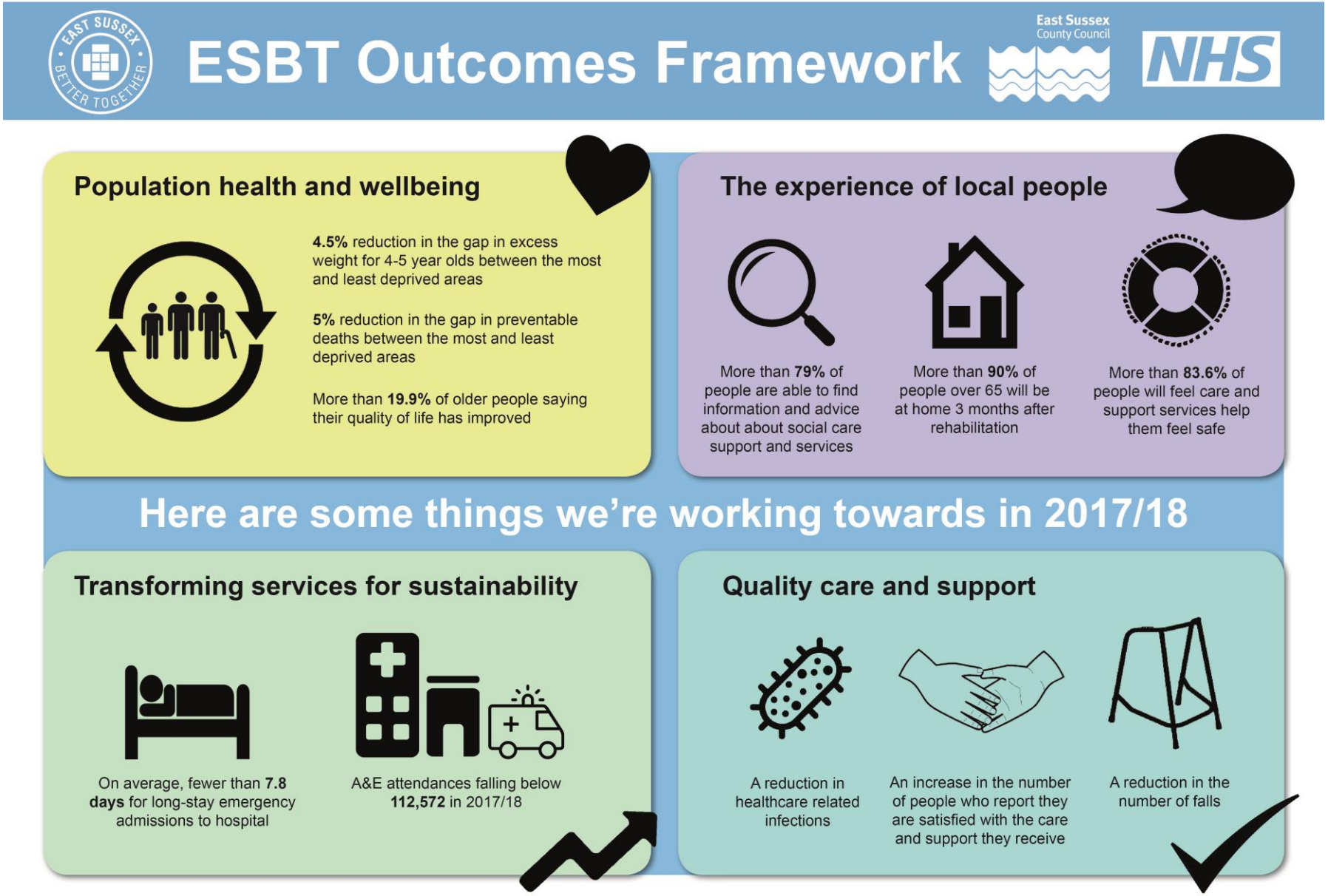
<table>
<tr><th>Year</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>EHS CCG</td><td>203</td><td>246</td><td>61</td></tr>
<tr><td>HR CCG</td><td>221</td><td>194</td><td>57</td></tr>
<tr><td>ESBT</td><td>424</td><td>440</td><td>118</td></tr>
</table></td></tr>
<tr><td>The number of falls in the population of local people</td><td>Reduction in falls

Data Source: ESCC use residents of East Sussex, diagnosis codes in first episode and includes specialised commissioning data.

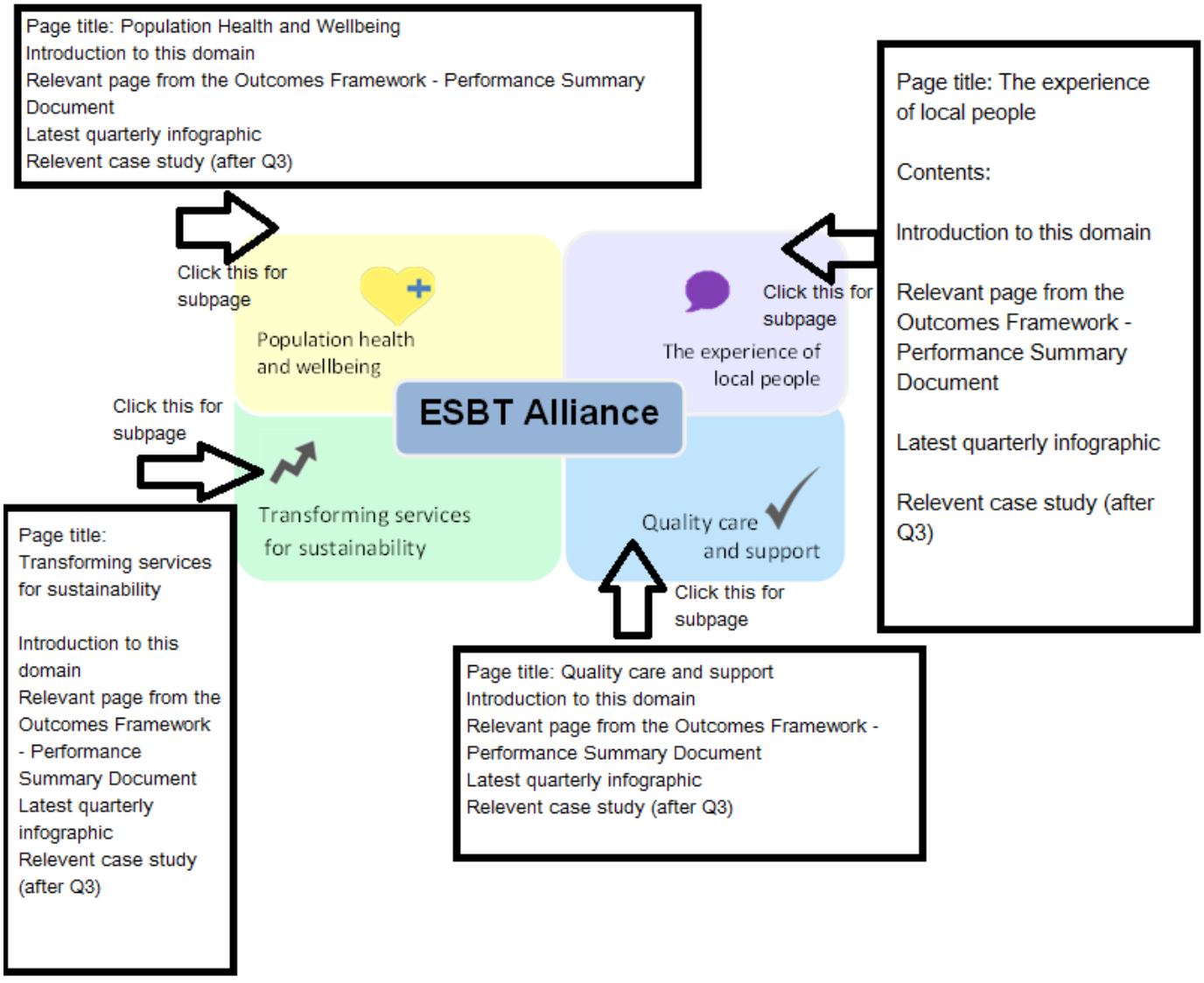
Emergency admissions for falls injuries classified by first diagnosis code, external cause and an emergency admission code. Age at admission 65 and over.</td><td> 

<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No of Falls</td><td>2,332</td><td>2,332</td><td>2,330</td><td>577</td></tr>
</table></td></tr>
</table>

Appendix 3: Infographic showing a selection of targets for 2017/18



Appendix 4: Web pages design and layout



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Report to: East Sussex Better Together (ESBT) Strategic Commissioning Board

Date of meeting: 2 October 2017

By: Chief Operating Officer, Eastbourne Hailsham & Seaford and Hastings & Rother Clinical Commissioning Groups

Title: East Sussex Better Together (ESBT) Alliance New Model of Care

Purpose: To note decisions made in July regarding the future arrangements for delivering health and care and strengthening the ESBT Alliance, and consider progress with further developing the ESBT Alliance and integrated strategic commissioning arrangements for 2017/19 onwards.

RECOMMENDATIONS

The Board is recommended to:

1) **Note the decision taken by each of the ESBT Alliance partner's governing bodies to proceed with further health and social care integration in the form of a single new health and care organisation by 2020/21**
2) **Note the agreement of each of the ESBT partner's governing bodies to accelerate this through strengthening the commissioner provider ESBT Alliance arrangement for 2018/19, to make the required year on year improvements to our system financial position and quality (as set out in the high level milestone map in Appendix 1)**
3) **Discuss the emerging approach to developing a single point of executive leadership for ESBT strategic commissioning**
4) **Note the proposed timetable and next steps as set out in section 6 to progress development and strengthen our Alliance arrangements for April 2018**

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1. Background

1.1 ESBT's initial 150-week phase has concluded and we have transitioned to our ESBT Alliance. Arrangements are now in place to ensure oversight of the whole health and care system from both a commissioning and delivery perspective. This Alliance phase is focusing on delivering in-year improvements across the system and developing the governance to deliver ESBT into the future. This will build on the work already delivered by our ESBT programme since it was established in August 2014, to integrate health and care in a way that achieves improved experience for local people; improved health and wellbeing outcomes; and delivers system sustainability.

1.2 The next phase focusses on building a new model of 'accountable care' that integrates our whole system – primary prevention, primary and community, social, mental health, acute and specialist care – so that we can demonstrably make the best use of the circa £1 billion collective resource we spend every year to meet the health and care needs of local people.

1.3 An options appraisal exercise was undertaken in June 2017 to consider the legal delivery vehicle options for the future ESBT model. The outcome of the options appraisal exercise was that an integrated health and care organisation is the preferred delivery vehicle. There was a strong appetite to implement this as the longer-term direction of travel by 2020/21.

1.4 It was additionally agreed that further strengthening our current ESBT commissioner provider alliance for 2018/19 would be a necessary next step in allowing us to make further year-on-year improvements to service quality and finances, in line with the expectations of our regulators and partners in the Sussex and East Surrey Sustainability and Transformation Partnership (STP). A high level milestone map, intended as a guide to support further phasing and detailed implementation is described in Appendix 1. These recommendations were put forward to the ESBT Alliance partners' sovereign governing bodies for their decision.

1.5 The plans to further formalise health and social care integration were approved in July 2017 by the governing bodies of the core ESBT Alliance Members; East Sussex County Council (ESCC); East Sussex Healthcare NHS Trust (ESHT), and; Eastbourne Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG).

1.6 Information about the options appraisal exercise, including a summary report detailing the exercise and the outcomes and the high level roadmap can be found on the ESBT website at http://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/esbt-future-model/

1.7 This decision has now been communicated to staff and stakeholders. We are now entering into an implementation period where much greater detail will emerge along with a comprehensive engagement plan. In line with this we have started to undertake further detailed phasing and implementation planning to deliver the high level milestones and strengthen our Alliance arrangements for April 2018.

1.8 This report provides a flavour of the feedback from the ESBT partner organisations' discussions of the recommendations in July, and provides an update on the emerging thinking and timetable to deliver a stronger ESBT Alliance arrangement for April 2018.

2 ESBT Alliance partner organisations' governing body discussions

2.1 Overall strong consensus was evident across the ESBT partner organisations on further formal integration being the overall preferred direction of travel for ESBT. This was seen to be the best way to continue to improve services, population health and wellbeing and ensure long term sustainability within our resource envelope. The full minutes of the July meetings of ESCC Cabinet, ESHT Trust Board and the CCG Governing Bodies are available on each organisation's website. A flavour of the key points from the discussions is provided below:

- Agreement that strengthening the ESBT Alliance arrangement for 2018/19 was a necessary next step on the journey towards integration. In terms of deliverability further formalising the Alliance was seen to be the best way to mobilise the current system to manage the service quality, financial and demand risks that we face;
- However, it was also acknowledged that maintaining separate organisational structures will place a burden on managerial capacity in the interim, as well as the difficulty of managing differing and sometimes competing agendas that are currently a part of our system without full integration. This extended to a desire to see the proposed timetable for fuller integration accelerated wherever this is possible, including exploring the opportunities for streamlining governance and decision-making;
- There was a desire to see the detail that comes out of further implementation and phasing for formal integration, for example workforce and financial elements;
- The high levels of citizen ownership that are achievable through a setting up a new single health and care organisation were noted as being a strong positive. This was seen to be important in both the formal Alliance arrangement as well as the long-term ESBT future model;

- It was felt that there should be a single strategic plan for the ESBT Alliance that brings together resources across commissioning and delivery;
- It was recognised that a strengthened approach to locality planning and delivery will be needed to support in-year delivery of improvements and the Strategic Investment Plan (SIP); and
- The concept of a single point of governance, leadership and management of our commissioning resource was supported as the best way to deliver improved health and wellbeing of our local population and improved service quality and finances, by enabling us to focus ESBT Alliance resources, staff, time, and energy clearly on our 'place'.

3. Strengthening our ESBT Alliance arrangement for 2018/19

3.1 We have agreed to strengthen our current ESBT Alliance arrangement for 2018/19 as a stepping stone to our preferred delivery vehicle of a new single health and care organisation by 2020/21. This is seen to be the best way to continue to improve services, population health and wellbeing and ensure long term sustainability within our resource envelope.

3.2 Formalising our Alliance further will help us to mobilise the current system to manage the service quality, financial and demand risks that we face. As part of this we have agreed to determine a single leadership of our integrated commissioning function, as well as a single leadership of our provider function and the way in which we organise services. This will help us to strengthen our commissioning expertise in an integrated way, with a clear focus on population health and outcomes to drive improvements.

4. Single point of leadership for commissioning

4.1 A single point of leadership and management of our commissioning resource, together with strengthened integrated governance arrangements, is considered to be the best way to deliver clinically led and locally accountable improvements to the health and wellbeing of our population. It will also better enable us to focus on quality and system finance and sustainability by channelling ESBT resources, staff, time and energy clearly on our 'place'.

4.2 In line with the current regulatory context Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG), Hastings and Rother Clinical Commissioning Group (HR CCG) and East Sussex County Council (ESCC) will remain as separate sovereign organisations, and will put in place arrangements for 2018/19 that enable joint accountability through a single executive leadership. This will help us commission 'as one', based on population health needs in the best interests of our local population. Early discussions have taken place in August and September to help shape our understanding of how a single point of leadership for integrated commissioning could take place. The emerging approach is underpinned by putting the following key elements in place:

- A single executive leadership role for strategic commissioning across our whole health and social care system. This will be supported by a single integrated executive leadership team that would deliver the strategic commissioning functions of both the CCGs and ESCC social care.
- Strengthened integrated governance arrangements to enable the proper discharge of our functions, reducing duplication where possible and demonstrating robust decision-making within agreed frameworks.
- A pooled and aligned budget for our whole health and care system will need to be put in place in readiness to support our ambition by April 2018, (work is being taken forward in parallel to put in place the underpinning financial arrangements to support integrated whole system commissioning for our population).
- Statutory responsibility will remain with the sovereign organisations (EHS and HR CCGs and ESCC)**,** as the organisations responsible for commissioning the majority of health and

care services respectively for the local population, and arrangements will need the agreement and assurance of those bodies, as well as NHS England (NHSE).

4.3 Some further assumptions that characterise the emerging model include:

- The single leadership of commissioning will be delivered from our existing system through a probable coming together of the CCG Accountable Officer function and ESCC chief officer functions.
- In order to maximise the benefits of this approach, this is likely to take the form of a secondment arrangement which will need to include formalisation of the accountability of the role and formal recognition across the EHS and HR CCGs, ESCC and NHSE.
- Retention of capability and capacity across our system will be critical to success.
- The single integrated leadership team would need to be able to discharge both CCG and ESCC social care functions in the following areas:
    - Health economics, Public Health and Joint Strategic Needs Assessment
    - Planning, strategy and engagement to identify and set outcomes
    - Nursing and care quality, patient safety and safeguarding
    - Monitoring and performance managing the delivery of outcomes
    - Strategic finance, system governance and risk
- Formal arrangements will need to be put in place to support this to enable both the CCG and ESCC systems of accountability where individuals are responsible for functions on behalf of the health and care organisations. This will be managed within existing organisational arrangements, and to avoid unnecessary disruption there is no intention to make changes to current employment terms and conditions as part of alliance arrangements.
- We will need to take a transitional approach to ensuring we have the right balance of staffing capacity to support the strategic commissioning function and those that will, over time, be aligned with the move to a health and care delivery organisation. As part of this there will be an ongoing process to involve staff beneath senior management team level in the integration of health and social care strategic commissioning functions as this becomes clear. To support this work is being undertaken to further align functions across our ESBT Alliance to support both remits of strategic commissioning and tactical commissioning to enhance core health and care services and care pathways and to support operational delivery. A brief explanation of the three layers of commissioning that take place across our Alliance is contained in Appendix 2.

5. Timetable

5.1 A proposed high level timetable has been developed to reflect the growing understanding of our approach as follows:

Ongoing engagement	Activity	Timeline
	Development of approach, discussion and testing	August and September 2017
	Further discussion, testing and finalisation of proposals, including aspects of commissioning to be delegated to STP-level and to locality level Shared impact assessments	October 2017
	Final proposals brought to the Alliance Governing Board	November 2017
	Recommendation of proposals to sovereign bodies: • EHS CCG and HR CCG Governing Bodies • ESCC Cabinet	November - December 2017
	Agreed process for single point of commissioning leadership role	January 2018
	Strategic Investment Plan and pooled/aligned budget finalised and agreed • EHS CCG and HR CCG Governing Bodies • ESCC Cabinet	January – March 2018
	Integrated senior leadership team agreed process	February - March 2018
	New formalised ESBT Alliance arrangements in place: • Phased implementation to strengthen integrated governance arrangements Singe leadership role and team in place • High level approach to transitional arrangements and alignment of staff in functional areas of strategic and tactical/operational commissioning	April 2018

6. Next steps

6.1 As part of making progress in line with our timetable, in the following weeks we will need to agree and establish a process to support the development of the single executive leadership role and top tier executive leadership team. This will also take into account our developing understanding of the transitional arrangements for commissioning capacity across our system.

6.2 Building on previous comprehensive stakeholder engagement throughout the development of ESBT and our new model of accountable care, we will further test our plans with our stakeholders in the coming months and undertake shared impact assessments, ensuring population benefits are clear. This will include regulators and will take in considerations of scope, including which aspects of strategic commissioning would likely take place as part of Surrey and East Sussex STP-wide commissioning where this makes sense.

6.3 In addition we will complete an exercise to review and strengthen governance and assurance of our system ready for 2018/19. This will include looking at the purpose and remit of the existing board meetings within our ESBT Alliance governance arrangements and also those of sovereign bodies in order to manage commissioning on a system-wide basis. This will involve forming a view of where we can safely reduce duplication by further strengthening the roles and function of the integrated ESBT Strategic Commissioning Board and ESBT Alliance Governing

Board, and making best use of our existing clinical and lay leadership across the system. In practice, and based on learning from the UK Vanguards and other early implementers, it looks as if this likely to mean:

- Phasing in an alignment of existing governance arrangements across all of the ESBT Alliance partner organisations to reduce duplication and manage the business more efficiently, at the same time as enabling statutory duties and strategic direction to be discharged. This would take place within a clear framework of appropriate delegation and a robust management of statutory functions.
- Strengthening the function of the integrated ESBT Strategic Commissioning Board, through utilising existing roles within the CCG Governing Bodies, such as clinical and lay leadership, in this setting. Similarly we will explore the potential increased role of the ESBT Alliance Governing Board to manage core elements of business.

6.4 Work undertaken to support the above actions will form the basis of proposals to the CCG Governing Bodies in November and Cabinet in December, with feedback on decisions coming to the ESBT Strategic Commissioning Board at its December meeting.

6.5 Work will also take place in the coming weeks to take forward the single leadership and management of delivery of how services are organised.

6.6 Plans are also in place to carry out a further round of joint ESBT staff engagement events in the coming months to follow up on the engagement events that were held in May.

Conclusion and reasons for recommendations

7.1 The ESBT Alliance sovereign organisations' agreement to the recommendations in July demonstrates that consensus has been reached across our system on the overall direction of travel for ESBT, and the best way to continue to improve services, health and wellbeing and ensure long-term sustainability within our resource envelope.

7.2 Strengthening our accountable care system by moving towards single leadership and performance management of our commissioning resource, alongside strengthened integrated governance, by April 2018, will enable a stronger more influential voice to underpin our shared ambitions for the ESBT 'place' and properly focus our work on population health and wellbeing outcomes based on evidenced best practice.

7.3 In order to prepare for April 2018 we need to develop clear proposals to enable our ESBT Alliance system to move towards single leadership, governance and management of our commissioning resource, and single leadership of the delivery function and how services are organised. Strengthened performance against our integrated Outcomes Framework and an integrated approach to regulation will be a necessary part of that.

7.4 Alongside further discussions at the ESBT Accountable Care Development Group and ESBT Alliance Governing Board, engagement and the contribution of our key stakeholders has been a key strength of our approach to date. We will continue to build on this through discussions at other new and existing meetings and events during the autumn as we continue to seek the valuable insights and input of our stakeholders as appropriate along the way.

7.5 The Strategic Commissioning Board (SCB) is therefore recommended to:

1) Note the decision taken by each of the ESBT Alliance partner's governing bodies to proceed with further health and social care integration in the form of a single new health and care organisation by 2020/21
2) Note the agreement of each of the ESBT partner's governing bodies to accelerate this through strengthening the commissioner provider ESBT Alliance arrangement for 2018/19, to make the required year on year improvements to our system financial position and quality (as set out in the high level milestone map in Appendix 1)
3) Discuss the emerging approach to developing a single point of executive leadership for ESBT strategic commissioning

4) Note the proposed timetable and next steps as set out in section 6 to progress development and strengthen our Alliance arrangements for April 2018

JESSICA BRITTON
Chief Operating Officer, EHS and HR CCG

Contact Officers: Vicky Smith

Tel. No. 01273 482036

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ESBT MILESTONE MAP

APR '17

MILESTONE

Stakeholder engagement to inform options appraisal on future organisational form

JULY '17

MILESTONE

Organisational form and development timeline agreed by sovereign organisations

DEC '17

MILESTONE

Clarify menu of options for how primary care, mental health and other parts of system relate to chosen model

APR '18

MILESTONE

Integrated single leadership structure for strategic commissioning function implemented; pooled budget and risk share agreed for strengthened Alliance
Single leadership of delivery function implemented.

APR '20

MILESTONE

Launch of new accountable care organisation

JULY '18

MILESTONE

Business case for accountable care organisation Agreed; NHSE ISAP process initiated

SEPT '18

MILESTONE

Plans for consulting with staff in place, as required

APR '19

MILESTONE

Integrated business infrastructure in place, including potential delegation to STP level

SEPT '19

MILESTONE

New integrated regulatory framework and payment mechanisms agreed

NB this map of high level milestones is intended as a guide, and milestones may be subject to change with detailed implementation planning

Ongoing staff and stakeholder engagement

Year on year delivery of financial balance and quality improvement

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Layers of commissioning functionality within the ESBT Alliance* Appendix 2

Based on the learning undertaken so far it is recognised that there three levels of commissioning functionality at play in our ESBT Alliance. These are set out in the table below:

Strategic Commissioning

Longer term strategic planning for the health and wellbeing of the population, in line with the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and other joint commissioning strategies. The strategic commissioning function has responsibility to advocate on behalf of the population and influence across the wider determinants of health: for example, education, housing, employment etc. as well as influencing and commissioning across and beyond ESBT's boundaries; at STP, regional and national level.

The strategic commissioning function is responsible for defining the outcomes required for the population from the system, informed by the JSNA and engagement with our local population. As we move towards creating a formally integrated health and care delivery organisation, it will ultimately be the role of strategic commissioning to develop and manage the outcomes and contractual framework for a capitated outcomes-based contract, as well as monitor and oversee the performance. Strategic commissioning is the term used for all the activities involved in:

- assessing and forecasting needs
- identifying the desired health and wellbeing outcomes for the population
- engaging and consulting with the public and services users
- strategic planning and linking investment to agreed outcomes
- monitoring and performance managing contracts in line with the required outcomes. In the future this would take the form of a single overarching contract with the new accountable health and care delivery organisation
- being responsible for assurance and oversight of statutory responsibilities such as quality, safety and safeguarding, emergency planning and business continuity

Tactical service commissioning, redesign and improvement

This is any activity involved with redesigning, improving or enhancing and supporting the delivery of core public health, health and social care services and care pathways. Where services are commissioned they are often provided by a range of providers, including the voluntary and community organisations, and social enterprises, and developing care markets is critical. Services and care pathways usually cover a specific segment of the population, need or geographical area (particularly as we move to a more locality focussed model of planning and delivery which will be underpinned by this type of commissioning activity).

Involving patients, service users and carers directly, as well as other key stakeholders, is a pre-requisite of making changes to services and care pathways to ensure their expert voice is heard in the process to optimise success and effectiveness.

As we move towards creating a formally integrated health and care delivery organisation, it is envisaged that tactical commissioning will increasingly become the responsibility of the new organisation, to ensure clinical and care leadership necessary to deliver the outcomes in the overarching capitated contract.

Operational (individual) commissioning

This largely refers to decision-making to meet an individual's needs by clinicians and care practitioners; it includes individual packages of care resulting from individual assessments (including Direct Payments, Personal Budgets, Continuing Healthcare and Personal Healthcare Budgets), as well as individual onward referrals for treatment pathways and/or more specialist services. Care packages, services and treatment pathways can be provided internally from within our core health and care system, other NHS Trusts and providers, and the independent care sector, micro businesses and Personal Assistants, and again market development is essential to ensure a diverse range of provision that can respond to health and care needs.

At its most effective operational commissioning with individuals should be done as a partnership between clinicians and care practitioners and individuals to build on people's individual strengths and circumstances.

**Content adapted from Somerset STP 'Proposal for the Development of a Joint Commissioning Function' (July 2017)/various sources*

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Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of report:	**2 October 2017**
By:	**Director of Adult Social Care, East Sussex County Council; and Chief Officer, Eastbourne Hailsham & Seaford and Hastings & Rother Clinical Commissioning Groups**
Title:	**Collaborative Health and Wellbeing Stakeholder Group**
Purpose:	**To update on progress with the set up and development of a new collaborative health and wellbeing stakeholder group**

Recommendations

The Board is recommended to:

1) **Note progress with the development of the new Health and Wellbeing Collaborative Stakeholder Group, including draft Terms of Reference for the Group and the recruitment process**
2) **Welcome a representative from the group at the next meeting of the SCB in December 2017**

---

1 Background

1.1 The aim of the project is to establish the overarching engagement arrangements required to support strategic planning for health and care in East Sussex. The scope is countywide and contributes to the shared planning processes and integrated governance arrangements across the East Sussex Better Together (ESBT) Alliance and the Connecting 4 You (C4Y) programme.

1.2 The ESBT Strategic Commissioning Board (SCB) considered the outcomes of the review in June 2017 and agreed to setting up a new collaborative Health and Wellbeing Stakeholder Group as the key mechanism to support citizen and stakeholder engagement in the strategic planning process. It was also agreed that a seat on the SCB would be made available to a representative of the new Stakeholder Group.

2 Supporting information

Progress with implementation

2.1 A Planning & Partnerships workshop was held on 7 July 2017 at the Bannatyne Hotel in Hastings. The report can be seen at Appendix 1. Over 125 participants attended the workshop and contributed to a series of themed table discussions on the development of a new stakeholder group for health and care. There was positive feedback on the event and all of those who completed a feedback form (71 people) felt able to participate and have their voice heard in the event.

2.2 Using the feedback from the workshop, the planning and partnerships working group have developed draft terms of reference for the new stakeholder group. These are attached at Appendix 2. To note, these will remain draft until the group itself is setup and agrees how it will operate. This includes the working title of the group 'collaborative health and wellbeing stakeholder group'.

2.3 Recruitment to the group went live mid-September and will conclude late October to allow maximum time for applications to be completed, returned and processed.

Independent Facilitation

2.4 Feedback from the workshop was consistent in suggesting the group should be independently facilitated. It was felt this will help to establish co-production within the group, support effective agenda planning, maximise engagement from group members, manage personalities, ensure the group is action-oriented and bring an independent perspective to help resolve alternative viewpoints among group members. A specification for the facilitation role is being drafted to be recruited to.

Role description

2.5 A comprehensive role description has been drafted detailing responsibilities of group members, anticipated time commitment and the skills/knowledge/experience/abilities required by those applying to be a community representative (this is included as an appendix in the Terms of Reference). While this level of detail will deter some people from getting involved, it is important we're upfront with our expectations and clear around what the role involves.

2.6 Representatives from health and care organisations will be expected to fulfil the same responsibilities, albeit without the recruitment process, as they are being asked to nominate an appointed representative to the group.

Support for the group

2.7 The support which stakeholder group members can expect to receive is also detailed in the terms of reference. This is important so that they are well informed and understand the strategic context in which the group sits.

Recruitment process in more detail

2.8 Recruiting to the group is challenging given its strategic focus and that we're seeking diverse representation and a combination of skills and abilities from community members. The July workshop concluded that neither an elective nor selective process are ideal, however, it is recognised we need to pragmatic and start somewhere. How members are appointed to the group can be reviewed and developed as the group evolves.

2.9 The recruitment process drawn up is both robust but also allows for expressions of interest from those who may be less experienced in engagement and representation. A number of requirements are specified and anyone interested in joining the group will be required to demonstrate how they meet these in an application form.

2.10 Publicity advertising the opportunity to apply is being disseminated across a range of networks and applications will be assessed by a cross-sector stakeholder panel. Criteria which demonstrate how an applicant fulfils a community connection are being weighted to ensure stakeholder group members each bring an informed perspective.

2.11 Statutory health and care organisations are being asked to nominate one representative to join the group. These individuals will be senior decision makers involved in strategic planning for health and social care, and will have an equal role in contributing to the discussions of the group. Healthwatch and the Registered Care Association (RCA) will also be asked to nominate representatives.

3. Next steps

Closing date for applications to join the Stakeholder Group	23 Oct
Assessment and shortlisting of applications	23 -27 Oct
Informal interviews and confirmation of appointments	1-8 Nov
First meeting, to include forward planning and team building	13-24 Nov
Induction and training ongoing	Nov-Dec

4. Conclusion and reasons for recommendations

4.1 A wide range of stakeholders has been involved in helping to shape the new stakeholder group. This has been a positive process so far and embedded co-production principles.

4.2 While stakeholder feedback has been rich, it has brought into focus a set of tensions around the group's role which it is important to recognise: it needs to be strategic in its focus and aligned with system priorities, but also take a bottom-up approach and focus on community-identified priorities; it needs to engage diverse groups in its membership but not be too large and unwieldy; it cannot be representative of all communities although others will confuse it as such; it is spearheading co-production at the strategic level but will not be responsible for making co-production happen at the service level, though can influence this. The group, with strong facilitation, induction, planning and support, will navigate and manage these tensions.

4.3 Having a clear focus on key strategic areas and achieving some quick wins will be important in winning hearts and minds and securing buy-in to the stakeholder group longer-term by demonstrating its impact.

4.4 Ensuring a strong connection to existing engagement mechanisms and information flows between the stakeholder group and others is critical to the success of this new way of working. The engagement landscape is complex and the ways in which this connection will happen are varied and will evolve over time. Consistent communications around this aspect of the group's work will be important.

4.5 An evaluation framework for the group will be drawn up to review how far we've gone in addressing the feedback from those consulted on the group's development and what its impact has been.

KEITH HINKLEY
Director, Adult Social Care & Health

AMANDA PHILPOTT
Chief Officer, EHS & HR CCGs

Contact Officers: Bianca Byrne / Sally Polanski
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Background documents:
None

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Planning and partnerships workshop report

7th July 2017, Bannatyne Hotel, Hastings

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact sally.polanski@eastsussex.gov.uk or call 01273 337293

Contents

Planning and partnerships workshop report
Executive summary

Background

East Sussex Better Together and Connecting 4 You have been reviewing how stakeholders input into strategic planning of health and care services. We have been thinking about how we can improve arrangements to ensure that we make best use of the experiences and expertise of stakeholders in shaping services.

As part of this review, a workshop was held on 7 July 2017 in Hastings, to which stakeholders with an interest in the strategic planning of health and care services were invited. The purpose of the workshop was to share some of the thinking which has emerged during the review of current planning arrangements and to explore ideas around setting up a new stakeholder group.

The workshop discussed development of a new health and wellbeing stakeholder group that will work collaboratively to help shape health and care across East Sussex. The intention is for the group to co-ordinate stakeholder engagement in strategic planning processes and to develop a countywide approach to co-production which will ensure commissioners and providers of services make best use of the experiences and expertise of stakeholders in improving health and care.

The new group will connect with the wide range of existing engagement mechanisms for involving people at all levels of the health and care system. The aspiration is to join up engagement activities and provide a meaningful route for stakeholders to inform strategy and decision-making.

The workshop

The workshop was jointly planned by a group of stakeholders from 3VA; Care for the Carers; East Sussex Parent and Carer Council; East Sussex Seniors Association (ESSA); Healthwatch East Sussex; Possability People; Southdown Housing Association; SpeakUp; East Sussex County Council; and Eastbourne, Hailsham and Seaford, Hastings and Rother and High Weald Clinical Commissioning Groups.

Over 125 people attended including people who use services, carers and representatives from a wide range of organisations (voluntary and community sector, NHS providers, commissioners from health and care, district and borough councils and others).

Presentations

The workshop included national and local presentations from a range of speakers:

- Welcome and scene setting: Paula Gorvett, Eastbourne, Hailsham and Seaford/Hastings and Rother Clinical Commissioning Groups (CCGs)
- Local context: Martin Hayles, Adult Social Care and Health, Jennifer Twist, Care for the Carers and Michelle Nice, East Sussex Parent and Care Council
- National best practice: Kristi Adams and Paula Fairweather, Coalition for Collaborative Care
- Close and summary of next steps: Ashley Scarff, High Weald, Lewes and Havens Clinical Commissioning Group.

Key points from the discussion sessions

In facilitated small groups, participants considered a number of key areas around how the new stakeholder representative group will function, including:

1. **The principles and values of the group**
   The proposed principles and values are positive but they should be made more concrete and demonstrate a tangible shift from current practices.

2. **What good collaboration and co-production should look like**
   Embed co-production at every stage, be realistic and flexible, involve as many people as possible, focus on vision and shared goals, think creatively and address potential barriers and blockages.

3. **Who needs to be involved**
   Have a balance of people who use services, special interest groups and cross-sector service providers, reflect communities of locality and identity and 'represent' people unable to represent themselves.

4. **How group members will carry out their roles and help they might need to be effective**
   Have defined role descriptions, training and support for members. Ensure effective planning for meetings, strong independent facilitation and feedback.

5. **How representatives will be recruited and selected**
   Use a selection process rather than election and review membership annually. The criteria should include: relevant experience, ability to engage / communicate / connect with communities and existing representative structures, the added value individuals bring and the values they demonstrate.

6. **How the group's agenda will be set**
   Focus on the right things, align with system priorities and have a forward plan, while enabling individuals and communities to put forward ideas.

7. **How other people and wider communities will feed in**
   Make use of a wide range of ways in which the group's activities can be promoted and experiences collected, to feed into discussions and decisions, including using technology and existing structures and networks.

8. **How the group will juggle competing priorities and demands**
   Prepare and plan well in order to handle this, and have strong facilitation.

Next steps

All the feedback and suggestions from the workshop will be used to inform how the stakeholder group is set up. Members for the group will be recruited September-October and a first meeting held in November. Participants in the 7th July workshop will receive information on staying involved and updates as the group progresses. We will produce a 'You Said …, We Did …' report detailing how key feedback has been acted upon and when the group has been operating for a year, everyone who participated in the workshop will be invited to reflect on progress made and consider how far we've been able to shape the group based on their input.

Background

East Sussex Better Together[1] and Connecting 4 You[2] have been reviewing how stakeholders[3] input into strategic planning of health and care services. We have been thinking about how we can improve arrangements to ensure that we make best use of the experiences and expertise of stakeholders in shaping services.

Purpose of the workshop

As part of this review, a workshop was held on 7th July in Hastings, to which stakeholders with an interest in the strategic planning of health and care services were invited. The purpose of the workshop was to share some of the thinking which has emerged during the review of current planning arrangements and to explore ideas around setting up a new stakeholder group.

The proposed new stakeholder group

The workshop discussed development of a new health and wellbeing stakeholder group that will work collaboratively to help shape health and care across East Sussex. The intention is for the group to co-ordinate stakeholder engagement in strategic planning processes and to develop a countywide approach to co-production which will ensure commissioners and providers of services make best use of the experiences and expertise of stakeholders in improving health and care.

The new group will connect with the wide range of existing engagement mechanisms for involving people at all levels of the health and care system. The aspiration is to join up engagement activities and provide a meaningful route for stakeholders to inform strategy and decision-making.

[1] East Sussex Better Together https://news.eastsussex.gov.uk/east-sussex-better-together/
[2] Connecting 4 You http://www.highwealdleweshavensccg.nhs.uk/our-programmes/connecting-4-you/
[3] By stakeholders we mean people or groups who have an interest in what an organisation does, and who are affected by its decisions and actions. Stakeholders include people who use services, their families and carers, voluntary and community sector organisations and independent providers.

Development of the stakeholder group

Development of the stakeholder group is being jointly planned by a working group of stakeholders from 3VA; Care for the Carers; East Sussex Parent and Carer Council; East Sussex Seniors Association (ESSA); Healthwatch East Sussex; Possability People; Southdown Housing Association; SpeakUp; East Sussex County Council; Eastbourne, Hailsham and Seaford and Hastings and Rother and High Weald Clinical Commissioning Groups.

The stakeholder group's terms of reference will evolve and be confirmed by the group itself as and when it sets up in the autumn of 2017. This will make clear the group's remit, ways of working and its strategic focus.

The recruitment process for stakeholder group members is being worked up and will go live in September/October 2017. Further information will be send to participants of the 7th July workshop, to keep them informed of the development process and for anyone wanting to have continued involvement in the work.

The workshop

Over 125 participants attended the 7th July workshop. They included people who use services, carers and representatives from a wide range of organisations (voluntary and community sector, NHS providers, commissioners from health and care, district and borough councils and others).

The opening session included the following presentations:

- **Welcome and setting the scene**: Paula Gorvett, Eastbourne, Hailsham and Seaford/Hastings and Rother Clinical Commissioning Groups (CCGs)
- **Local background and context**: Martin Hayles, Adult Social Care and Health, Jennifer Twist, Care for the Carers and Michelle Nice, East Sussex Parent and Care Council
- **National best practice**: Kristi Adams and Paula Fairweather, Coalition for Collaborative Care

Participants were then asked to discuss how the proposed stakeholder group should function. Their ideas and suggestions were gathered on the following themes:

1. The principles and values of the group
2. What good collaboration and co-production should look like
3. Who needs to be involved
4. How members of the group will carry out their roles and the help they might need to be effective
5. How group members will be recruited and selected
6. How the group's agenda will be set
7. How other people and wider communities will feed in

8. How the group will juggle competing priorities and demands

The workshop closed with a summary of next steps by Ashley Scarff, High Weald, Lewes and Havens Clinical Commissioning Group.

This report

We have analysed the rich and valuable contributions made at the workshop under the 8 sections above. The working group also reviewed this information and helped shape this report.

The first discussion session focused on the draft principles and values of the Stakeholder Group. Comments have been taken on board and written up as a revised set of principles and values, as there was sufficient clarity and consensus across the workshop to achieve this.

The remainder of the report summarises key messages which emerged from discussion sessions 2-8. It is a record of the event which enables everyone who participated, and those who didn't attend, to get a flavour of the discussion and themes emerging. In order to make the report accessible, it does not detail all the diverse comments that were made – although these are held in separate files for future reference.

The suggestions which came out of the workshop will be used to inform how the stakeholder group is set up in coming weeks.

A subsequent 'You Said …, We Did …' report detailing how key messages and themes have been acted upon will be produced.

Once the group has been operating for a year, everyone who participated in the workshop will be invited to reflect on progress made and consider how far we've been able to shape the group based on their input. This will form part of the monitoring and evaluation framework for the group.

Discussion sessions

1. The principles and values of the new stakeholder group

A set of draft principles and values were presented to the workshop for participants to comment on (see appendix one).

What you said

Participants were broadly positive about the proposed principles and values but suggested they should be made more concrete and demonstrate a tangible shift from current practices. There was also a sense that the principles and values need to be more inspirational and their outcome monitored.

Comments have been used to produce a revised set of principles and values, which relate both to how the group will work but also its role in championing co-production within health and care:

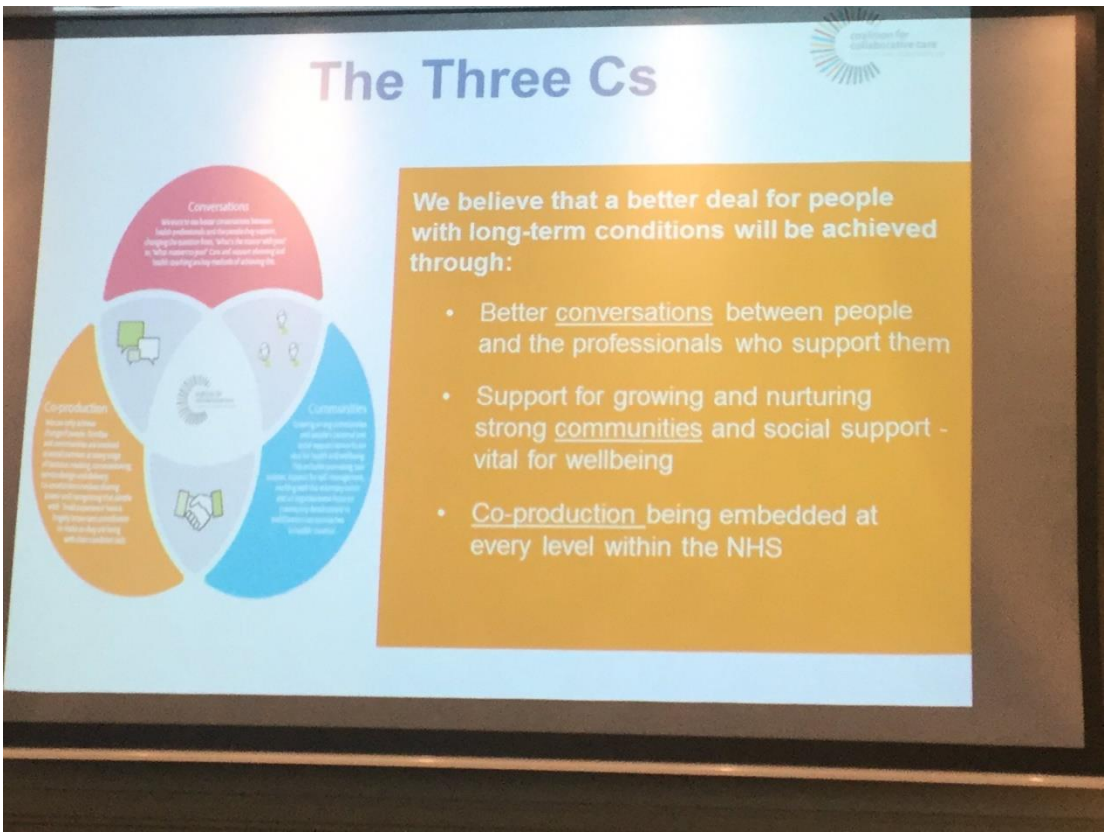
1. We adopt co-production[4] as a way of working
2. We will change behaviours, striving to involve people as early as possible
3. We create opportunities for people to participate so they can make things better for others
4. We recognise people's strengths and resilience, embrace diversity and value people's experiences
5. We listen and make sure that all voices are heard and acted upon
6. We empower people to have a say on what matters to them: participants will decide on meeting agendas and priorities
7. We will be clear and transparent around what can and can't be influenced, at what level and who is responsible for making decisions. While we aspire to everyone being equal in and to flatten hierarchy, we know that sometimes power dynamics will impact. We will be honest about this, monitor its impact and challenge where necessary
8. We are interested in all things: influencing plans, changing practice/culture and deciding how money is spent
9. Participants can see if and how their views have influenced: we will get timely feedback on our input and understand our impact
10. We are mindful of people's capacity to engage and will address barriers to participation as much as possible. We use plain English and a wide variety of channels of communication to ensure information is co-ordinated, reaches people in the best way possible and is up to date

[4] Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

11. The success of the new approach is everyone's responsibility. We will hold different views and be required to make difficult decisions
12. We expect to make mistakes, capture them and learn from them

Participants also commented that:

- While the principles and values sound great, similar things have been said in the past. How will the principles and values be embedded and followed by everyone involved? There needs to be accountability around outcomes that relate back to the principles and all parties need to recognise that change will be difficult as it might involve giving something up, such as the way in which something has been done before
- Where the stakeholder group sits in the decision-making structures is unclear and this and the routes to influence need to be clarified
- The importance of building a strong understanding of the health and care system cannot be over-emphasised; the group must have advanced knowledge around who does what
- Principles and values need to be reflected in all parts of commissioning
- The term stakeholder needs consistent definition
- It would be helpful to clearly distinguish collaboration from co-production



Extract from Coalition for Collaborative Care presentation

2. What good collaboration and co-production should look like

The proposed stakeholder group will help ensure co-production is happening at a service level across the health and care system and drive forward good practice in working in partnership around service design, development and evaluation.

Participants commented on their experiences of collaboration and co-production, what they've seen work well, what hasn't and priorities for consideration in developing this new approach.

What you said

2.1 Embed co-production at every stage:

- In setting priorities, in problem solving, from start to finish in a meaningful way
- Using the 'plan, do, study, act' cycle
- Be receptive to examples from elsewhere in the country and draw on them
- Avoid statements such as 'we will strive' which are loose and vague. Apply co-production consistently as much as possible and culturally across the whole organisation, although accept things will be missed out

2.2 Be realistic and flexible:

- Co-production cannot over burden key individuals as this risks burnout, there needs to be a group and a team approach
- Constraints and barriers will get in our way, eg organisational governance requirements, hierarchy, the law, culture and behaviours. Establish clarity of outcomes, but accept that these outcomes may be different from what was originally hoped for. Be realistic about expectations and honest about influence – not everyone can be involved in all decisions and not all contributions can be taken on board
- We need to confront challenges and remove barriers
- Accept there will be frustrations and be honest about the decisions that have been made and why
- Good collaboration requires good planning, which takes time and a slow pace

2.3 Involve as many people as possible

- People who use services and people with lived experience are more likely to be able to come up with solutions to the problems faced in their own lives
- Everyone's contribution is valid and difference is valuable
- Engagement champions eg disabled people, could strengthen under-represented user voice
- Diversity of backgrounds/skills is important in collaboration
- Enable collaboration between organisations with common interests to identify priorities

- Showcase when engagement of diverse groups works well
- Appreciate that people wear different hats and may fit into lots of engagement categories
- There needs to be a shared responsibility of working together, mobilising co-production, building trust and creating a space for collaboration which is honest, real and which says positive as well as negative things
- All this said, someone has to lead co-production to make it happen
- It will be more efficient for some tasks to be carried out by those who are more experienced at them
- The new stakeholder group isn't in itself co-production and co-production isn't about just engaging one stakeholder group or having one set of meetings. It's about being proactive, going out to groups, using different communication channels to share information, developing ongoing involvement and finding the right people to talk to, across whole organisations
- Stakeholders need access to training and support to be involved and meetings need to be accessible. This includes staff and professionals from health and care organisations who need to develop their skills around engaging with the community

2.4 Focus on vision and shared goals

- Work backwards from this, rather than trying to start off with budgets
- Find something people really care about and focus on decision making around outcomes
- Ensure we commission services that the community will actually use
- Don't lose sight of the user at the centre

2.5 Think creatively

- Don't be afraid of starting with a blank sheet of paper (whilst also recognising the potential for impact may be greater if existing processes and plans are targeted for influence)
- Service agreements need to focus on people rather than deliverables
- Make the environment okay for people to question jargon and bring out different types of knowledge
- Create the right sorts of spaces to enable people to have a voice – not everyone wants to sit in a formal room in a meeting
- Communicate via GP surgeries, pharmacists, social media and much more

2.6 Address potential barriers and blockages

- Statutory budgets need to be properly pooled before co-production can be achieved, to avoid disagreements over who funds what
- Lack of understanding of what's available/where/from whom can undermine collaborative working

- Commissioning can create challenging operating circumstances for the voluntary and community sector (VCS) and trigger instability in the system. Is there a better way of handling this? Can we ensure we learn from and build on what went before?
- There aren't enough opportunities for organisations and people to network, connections to and involvement of district and borough councils in particular need to be improved
- The approach focuses on pulling together issues at the countywide level. Will localised issue be considered? The locality networks provide a local contact point for people to get involved in sharing their experiences and feeding into the stakeholder group
- Operational pressures do not allow time for co-production
- Previous poor practice, eg lack of transparency around decision-making or weak representation of user voice/small groups, creates cynicism and lack of buy in.

A list of good practice examples of collaboration and co-production were shared and are being used to shape development of the new group.

3. Who needs to be involved

What you said

Participants discussed membership of the stakeholder group and who needs to be involved. The group needs to:

- Have a balance of people who use services, special interest groups and cross-sector service providers
- Reflect communities of locality and identity
- Ensure small groups' views are represented and not lost in the mix, but guard against having too many group members
- 'Represent' the most disenfranchised people unable to represent themselves/with a minority voice/protected characteristics including:
  - Children, young people, parents
  - Disability (physical, learning, sensory)
  - Older people, socially isolated
  - Carers
  - Rough sleepers
  - Faith groups

  Although the group should not be described as, or labelled, representative
- Have a broad understanding of communities and their needs, with capacity to advocate, challenge constructively, communicate, to build trust and relationships and be open-minded
- Link with a range of voluntary and community sector organisations. Although the VCS needs a more co-ordinated approach to representing itself
- Have participants from East Sussex County Council, Clinical Commissioning Groups, NHS trusts, Healthwatch, Districts & Boroughs, Police, East Sussex Fire & Rescue Service, South East Coast Ambulance Service
- Build on engagement and representation that already exists, eg East Sussex Seniors Association, Speak Up, Eastbourne Involvement Group and people previously on the boards being disbanded
- Cover the needs and interest of different localities. Locality networks provide a route for local experiences to be gathered and fed into the group. Locality Link Workers (LLW) will help channel communications/connections
- Be flexible in its approach, eg to engage different people as guests/speakers according to the theme of the meeting or for members to send substitutes
- Involve around 20-30 people to keep it manageable.

It was agreed that fluid membership/irregular attendance would alter the way in which the group operates and its potential impact. A static fixed-term membership, with continuity of attendance, will facilitate persistent influence and develop consistency in relationships.

It was also queried whether organisations that commission or provide services should be included in the group because of the potential impact on the power dynamic. Most favoured provider involvement but stressed the need for a balanced approach with a minimum number/majority representation of non-providers.

4. How members of the group will carry out their roles and the support they might need

What you said

Participants discussed how stakeholder group members would carry out their roles, what the challenges and opportunities might be and what support might be needed for the approach to be effective. It will be important to:

- Make expectations clear in defined role descriptions
- Brief and support members of the group
- Provide learning and development support to include (tailored, modular):
    - Skills based training on effective representational skills, confidence building, team working, assertive communications
    - Facilitated team development for the group on its values and principles, ways of working, possible action learning set approach to this over time
    - Information briefing on health and care strategy
- Plan the meetings well. Make them outcome rather than task focused. Through early agenda distribution allow group members time in advance to engage communities they're connecting with to seek input and gain mandate
- Ensure strong facilitation, use participative methodologies, accessible venue/times, ground rules, techniques to ensure everyone has the opportunity to participate, plain English and have a culture of no silly questions
- Have independent chair or facilitator, balancing formality, informality, creativity
- Invite specialist speakers / attendees as required
- Budget for reward and recognition costs
- Feedback to group members on what difference their input has made

It is necessary to also consider:

- How the group feeds back to wider communities
- The limits of the group's influence, constraints, accountabilities and have clarity around impact on whole system planning. The demands of the role need to be proportionate to this
- Whether the group needs branding to help with building awareness and trust
- What happens outside meetings of the group eg activities/interactions in between meetings eg via digital and social media / cascading information / task and finish groups on different subjects / leadership sessions
- That individuals will bring expert views but also perspectives as members of the community. Direct experiences are valid to ensure a balanced approach but it's important to separate out individual personal experience from 'representative' input
- Members of the group need to bring objectivity and impartiality.

5. How group members will be recruited and selected

What you said

Participants discussed their ideas on how stakeholder group members should be identified, recruited and selected.

- It was acknowledged that neither selection nor election are ideal processes for recruiting group members. There isn't an obvious / straightforward route to election currently, so selection is the most immediate sensible option, although the governance around this needs to be robust and the challenge will be to minimise bureaucracy and barriers to participation
- Recruitment and selection will be based on applicants' capacity to fulfil the role requirements based on:
    - Relevant experience
    - Ability to engage/communicate/connect with communities and existing representative structures (some places could be retained for representatives from existing forums)
    - Added value individuals bring and the values they demonstrate
    - Ability to demonstrate impartiality
- Representatives from statutory organisations will be senior decision makers with the knowledge and authority to explain directions and decisions
- Applicants should self-nominate/apply, to ensure buy-in
- The group member role description should include:
    - Skills required
    - Time commitment
    - Trial period, notice period, term of office
- The working group will oversee the recruitment process and the selection panel needs to be representative of communities as much as possible
- Publicity advertising the opportunity to join the group will be cascaded across as many networks as possible, to ensure good reach
- Membership of the group should be reviewed annually and harder to reach groups actively targeted to become members. There should be a staggered turnover / rotation of members to balance continuity with fresh perspectives
- Going forward, a wider assembly of anyone interested/attending engagement events, could elect members of the stakeholder group

It was acknowledged that while the group signifies a centralised approach to engagement, the emphasis is on there being diverse engagement activity around this and strong input from localities via the Community Networks.

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6. How the group's agenda will be set

What you said

Participants discussed how the stakeholder group agenda should be set and identified some top tips and ways forward.

6.1 Focus on the right things

- Develop a positive culture around agenda setting
- Don't overload the agenda: keep to key strategic issues only
- Agendas need to come from overall system priorities leading into action, ie looking at the impact on people's lives (the outcome), in tandem with organisational/strategic priorities
- Topics need to broadly be relevant for all, otherwise people may feel excluded (or exclude themselves)
- Standing agenda items could include:
    - Gaps in service provision
    - Innovative developments
    - Future developments and ideas/ agenda planning
- Themes could have an item on every agenda e.g. carer, mental health
- Use data to build evidence based practice
- Find solutions
- Councils can be risk averse. Challenge this by thinking outside the box.

6.2 Leadership and maintaining strategic oversight of agendas

- There shouldn't be a steering group as this risks distorting power of group and co-productive approach – better is for the whole group to prioritise topics
- Agenda setting has to be strategic and align with system priorities, if it's to have maximum impact and influence. Therefore ensure agenda setting considers views of users/ organisations/leaders
- Run a forward plan of items for the year with key deadlines/dates
- Require that all significant strategy/service change goes through the group (like the Equality Impact Assessment process)
- Consider what authority there is in chair/co-chair/facilitator role. Needs to be independent and fair

6.3 People put forward ideas

- Ask people in community what is important to them
- Ensure language is accessible
- Group members to invite communities/individuals to put forward ideas
- Think about how to get minority voices in as well as common issues
- Link to new provider forum on their views
- Get locality perspective

- Ask groups what engagement work they have already done / read minutes from meetings so to identify issues and priorities already known (eg Local Strategic Partnership meetings in districts and boroughs)
- Horizon scan for issues in communities
- Spend some time at the end of the group meetings to discuss topics for next time, eg on evaluation forms invite agenda items and ask people to rate them
- Use technology: email/survey monkey/website/noticeboard to collate priorities
- Group members use long list to form an agreed agenda
- Consider how different groups will feel comfortable/ capable of raising the issues that affect them, possibly via a buddy system

6.4 Manage expectations

- Have realistic conversations and be realistic about outcomes
- Avoid one group skewing the direction of focus. Do this by setting expectations, remit and boundaries, preferably as early as possible

6.5 Suggested potential agenda items

- Getting people out of hospital
- Social prescribing and signposting to non-medical “treatment” and support
- The development of Patient Participation Groups
- Allocation of resources
- Taking into account national priorities
- Identifying least cost effective areas of the system i.e. reducing reliance on costly residential care and prevention
- Learning from other areas

7. How other people and wider communities will feed in

What you said

Participants discussed what the group itself should do to secure input from wider communities and what else needs to happen around the group to achieve this.

7.1 What the group can do

- Promote itself and what it's doing online, so everyone is clear about what's happening and the opportunity to input
- Host an online discussion forum or have an app
- Cascade information in and out via the VCS and existing networks. Rely on those within group to liaise with wider community
- Use tech: Slido, webinars, live streams, Skype, Survey Monkey. Voting gives a responsibility to make a choice
- Put resource into engaging specialist groups
- Don't start from the beginning again! Pull out what we've already gathered via surveys, joint strategic needs assessments, research and evidence already collated. Check this evidence and ask stakeholders if anything has changed
- Hold the meeting in public so people can see it's transparent

7.2 What needs to happen around the group to secure wider input

- Collect experiences of using services and feed this in
- Have as many networking opportunities as possible
- Involve the District, Boroughs and Parishes
- Have contact points to help navigate / sign-post to the right point in the system to have a discussion
- Develop means for people to communicate their ideas / priorities eg have a suggestion box / social media equivalent. Invite all groups to put forward comments and these get analysed and considered (simple and easy)
- Have good communication and links between forums (eg share minutes)
- Have a strong relationship with HealthWatch
- Use locality networks, Locality Link Workers, 3VA, Rother Voluntary Action, Hastings Voluntary Action and Action in Rural Sussex
- Use residents associations/ housing associations

It was suggested that sufficient resource needs to be allocated to the group to ensure consistent quality of evidence gathering, distribution of information across communities and cascading feedback on outcomes of stakeholder input. There will also be costs associated with using trained facilitators and potentially commissioning community development work to support the group.

8. How the group will juggle competing priorities and demands

What you said

Participants discussed how both in meetings and via adequate preparation the group will be able to handle competing demands and juggle priorities.

8.1 Preparation

- Develop a shared evidenced based focus, to break down barriers and build collaboration
- There needs to be some direction given in terms of strategy, service directions, budgets etc but co-production principles will be followed by the group to determine order of priorities, the group's forward plan and each meeting agenda (with time and space for blank sheet thinking when useful)
- Follow priorities according to East Sussex demographics – e.g. deprivation pockets, transport in rural areas, large proportion of older people
- Avoid too narrow agendas
- If something is recognised as a priority, give it time

8.2 In meetings

- Have strong, high quality and skilled facilitation
- Don't stifle contributions, just because they don't fit with structured agendas
- Be clear on voting rights – are all group members equal or will some have more than others?
- Be clear about where issues are dealt with; make use of working groups
- Respect others roles and views. Recognise that people will have their own priorities and demands but that it is part of the strength of group

8.3 Other comments

- If principles and values are met, people will engage and be content to juggle
- Make sure that people at the strategic level can see the work/discussion that has gone into preparing stakeholder input
- Pose open questions
- Be sensitive to differences in localities
- Have courage to call out where the systems are failing
- Need a check in process / evaluation to assess priorities are right
- Be clear that people should come open to work at this
- Be transparent around what the priorities are and people will understand when things change/services reduced etc. Work in an honest and open way

Other points of interest

Participants made the following other comments/observations during the workshop.

- Members of the stakeholder group could host the meeting ie it moves around different settings
- It is very important to tell stories eg around impact of influence and learn from past engagement case studies
- There is a lack of information and communication around personal health budgets. They are therefore difficult to access.
- Information doesn't currently take into consideration audience. Public sector websites are too difficult to navigate

Questions asked on flipcharts

How does the new group relate to the Health & Wellbeing Board? How are the groups in the green section of the Health & Wellbeing Board chart linking to the localities / network / communities of practice planning forums at the bottom of the chart? [see chart which question refers to on page 23]	The stakeholder group will have a seat on the Strategic Commissioning Board of East Sussex Better Together (ESBT) and the Connecting 4 You (C4Y) Programme Board, which will then both feed into the Health and Wellbeing Board. This will ensure a strong flow of information and input from the group into decision making. Locality networks are open to various groups representing people and communities to engage with (see the green section on the chart). Locality networks are: • Recognising and building upon community assets and strengths and utilising the range of services on offer in local communities to help people to create their own network of support outside of statutory services • Supporting the community and voluntary sector in each locality to thrive, grow what is already working well, and have the capacity to respond to emerging priorities. • Identifying gaps in services and working with a wide range of stakeholders to come up with creative solutions and innovative services. Locality networks are new and evolving but provide a key route for experiences being gathered and shared. For more information, contact Rachael.Toner@eastsussex.gov.uk
What will this group actually do or be asked to do? Its purpose, role, remit needs to be clarified	The group will work collaboratively to help shape health and care across East Sussex. The intention is for the group to co-ordinate stakeholder engagement in strategic planning processes and to develop a countywide approach to co-production which will ensure commissioners and providers of services make best use of the experiences and expertise of stakeholders in improving health and care. The new group will connect with the wide range of existing engagement mechanisms for involving people at all levels of the health and

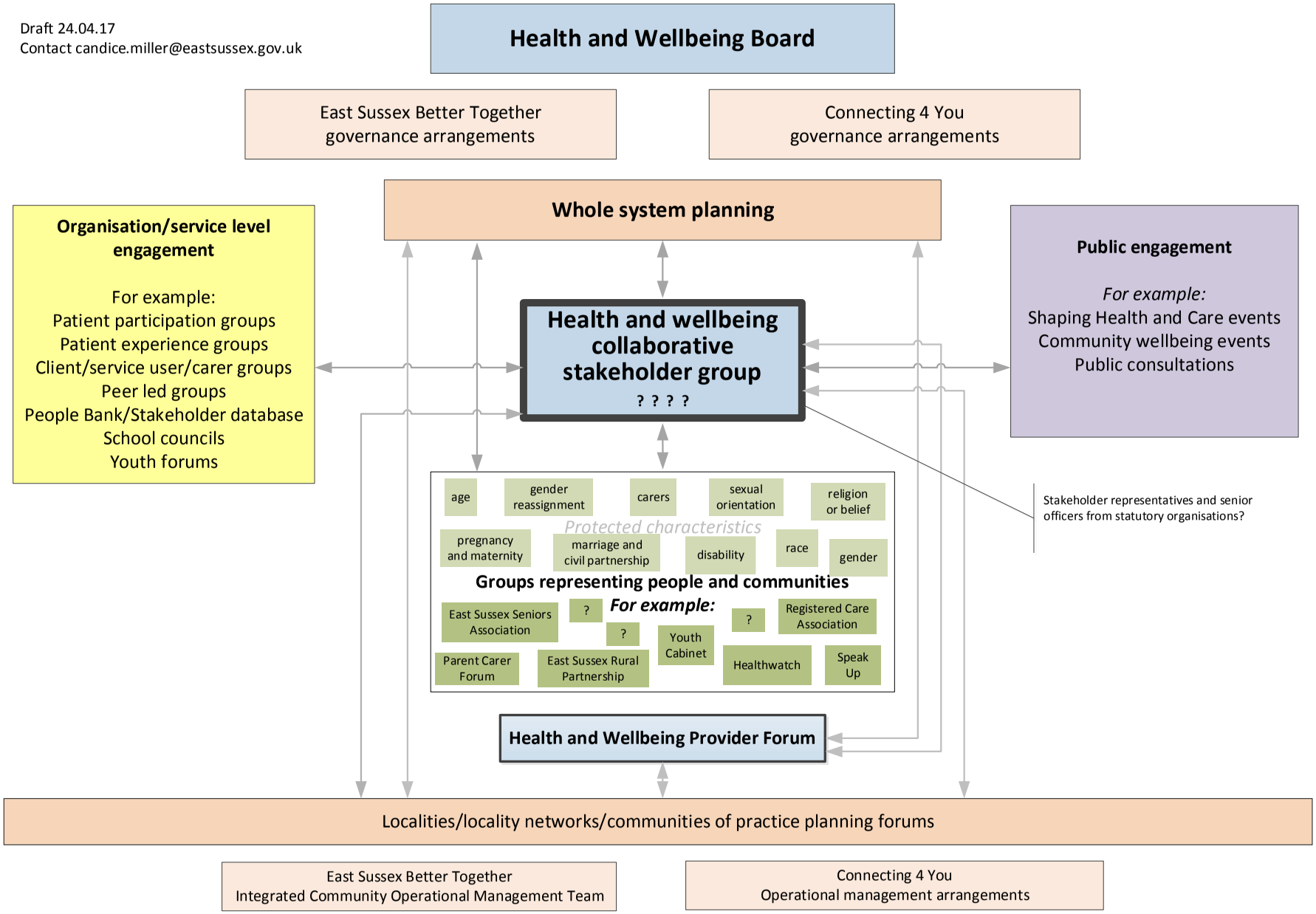
	care system. The aspiration is to join up engagement activities and provide a meaningful route for stakeholders to inform strategy and decision-making. The detailed role of the group will be set out in terms of reference which are being drafted by the working group and which will develop further as and when the group is set up.
What happened to the work that was happening in the Partnership Boards which have ended / are ending?	Any live issues or strategic / service developments which were being considered by the Boards will be transferred to the group to put into its work plan, if appropriate.
What are the expected outcomes of collaboration and co-production?	To improve services. As the group evolves, it will inform the ongoing development of co-production within health and care which will in turn drive practice across the system.

Questions asked on the Sli.do Tool

Can it be clarified who makes up the decision-making body (the whole system planning box above the stakeholder group in the pdf)?	The decision-making bodies are represented in the diagram by the ESBT and C4Y governance arrangements boxes. The whole system planning box is intended to represent whole system planning arrangements in ESBT and C4Y. These include groups that are responsible for developing the overall strategic direction in a particular area such as: • Community services • Urgent Care • Planned Care • Community and Personal Resilience • Primary Care • Learning Disabilities • Mental Health • Children's Services • Accommodation and Bedded Care Detail on this will be included in the supporting documents for the stakeholder group.
The diagram has lots of arrows. Do they represent physical participation, informal communication or specific terms of reference? Who maintains the relationships?	The arrows on the chart are intended to show that the groups and activities will be linked and interactions fluid – we will make this clearer in the version of the structure chart which accompanies information about the group in future. A briefing on the governance structures and the strategic health and care landscape will be provided to members of the group as part of their induction. The stakeholder group will have a seat on the Strategic Commissioning Board of ESBT and the C4Y Programme Board, to ensure a strong flow of information and input from the group into decision making. There will also be lots of other opportunities to input through the locality networks. Routes for communication and accountability will be made clear.
Is it not time that ESBT and Connecting for you were merged?	Connecting 4 You has been developed to address the specific needs of the High Weald, Lewes and Havens population and the geographical challenges to

	delivering sustainable NHS and social care services. The great majority of people access secondary care services from out of county providers – particularly from hospitals in Brighton, Hayward's Heath and Tunbridge Wells. This means that the High Weald, Lewes and Havens Clinical Commissioning Group has to contribute to planning for better integration and co-working across three health systems: East Sussex, Brighton & Hove & Mid Sussex, and West Kent.
How are small voluntary sector groups able to have their voice and be involved?	The new group will connect with the wide range of existing engagement mechanisms for involving people at all levels of the health and care system. The aspiration is to join up engagement activities and provide a meaningful route for stakeholders to inform strategy and decision-making, so that we collectively make best use of the information gained from stakeholders across the whole health and care system.
Will the commissioning of services change? Currently it's challenging for funded groups to talk openly with competitors, both local and national.	Potentially. Adult Social Care and Health is currently reviewing grants commissioned through the Prospectus to understand next steps around re-commissioning or de-commissioning these services. This might include looking at new models for commissioning VCS services in the long-term. Issues around the market and its experiences will be reflected and considered in the refresh of the market position statement later this year.
Are the draft principles and values going to be reflected right though the structure? How will the accountability actually work?	We think it would be helpful for the principles and values to be reflected right through the structure and will take this forward with the support of the new group. It will take time for all parties to be informed and for things to shift.
Are Locality Link Works the "Locality Reps?" (potentially/not?)	The main role of the Locality Link Workers is to bridge the gap between integrated health and social care teams and communities. Locality Link Workers will play an important role in making sure communities are connected into engagement structures and involved in conversations taking place, and therefore part of the strategic planning process. But they are not 'locality representatives'.

Draft 24.04.17
Contact candice.miller@eastsussex.gov.uk



Feedback on the workshop

Over 125 participants attended the workshop and the majority of participants fed back that they had a positive experience. 71 people completed a feedback form and all of those felt able to participate and have their voice heard in the event.

Participants valued most of all the opportunity to:

- Discuss and work with others
- Meet other participants
- Learn from other participants about their experiences and/or the work they are doing

There were three areas where participants felt the workshop could have been better:

- Surrounding noise as a result of the large number of people at the event sometimes made it hard to listen/take part
- The aims of day needed to be made clearer at the beginning and the proposals for the new stakeholder group introduced in more detail. The decision to not give detailed presentations was taken by the planning group in an effort to minimise information coming top down and protect space for bottom up conversations
- Lunch was limited and inadequate for vegetarians/vegans.

This feedback will be taken on board when planning future events.

Appendix I

Draft stakeholder group principles and values presented at the 7th July workshop for comment

- The views and experiences of all stakeholders are valued and respected.
- Our approach to strategic planning and decision making is transparent.
- We are clear on the level of participation with all our engagement activities
- We strive to involve people as early as possible and adopt co-production as a way of working wherever appropriate.
- People are empowered to have a say and help shape health and care provision.
- We work to make sure that all voices are heard.
- Stakeholders can see how their views have influenced the shape and design of services across all sectors.
- We communicate in plain English and we use all channels of communication to ensure information is easily found and accessible
- The success of the new approach is everyone's responsibility.

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Collaborative health and wellbeing stakeholder[1] group Draft terms of reference

Draft v10: September 2017[2]

[1] By stakeholders we mean people or groups who have an interest in what an organisation does, and who are affected by its decisions and actions. Stakeholders include people who use services, their families and carers, voluntary and community sector organisations and independent providers

[2] This draft terms of reference have been developed by a cross sector working group and will be revised and agreed by the stakeholder group itself upon its formation

Background

This stakeholder group forms part of engagement plans and governance framework for people and organisations to work collaboratively to help shape health and care in East Sussex. The group has been developed following a review of existing arrangements, extensive stakeholder consultation and engagement around alternative approaches and with input from a working group on the development process.

Where the group fits in the governance and operating frameworks for ESBT and C4Y is detailed in the diagram in appendix A. It isn't possible to easily capture on a page the complex interactions which the group will have, e.g. with engagement activities, integration workstreams, strategic planning processes, service pathways etc. The success of the group will depend upon the strategic landscape being well understood and navigated, which the group will be supported with by adult social care and health staff.

The group is about developing a shared responsibility for working together, mobilising and embedding co-production, building trust and creating a space for collaboration which is honest and real. Co-production is taken to include co-design and planning of services, co-decision around the allocation of resources, co-delivery of services, recognising users' assets and the role of volunteers in service provision, and co-evaluation of services. The group will be supporting a wider system move from involvement and participation towards people who use services and carers having an equal, more meaningful and more powerful role in services, where health and care professionals and people who use services work in equal partnerships towards shared goals.

1. The name of the group is:
Collaborative health and wellbeing stakeholder group (known as stakeholder group)[3]

2. The aims of the group are to:

- Ensure that best use is made of the experiences and expertise of stakeholders in improving health and care strategic planning
- Ensure stakeholders can input into and influence the strategic decision making processes in ESBT and C4Y. This will include setting priorities and allocating resources
- Inform the ongoing development of co-production within health and care which will in turn drive practice across the system.

3. The purpose of the group is to:
Help to define the overall strategic direction for commissioning health and care in East Sussex and ensure that stakeholders can input into the decision making process around how priorities are identified and resources are allocated. They will do this by:

- Co-ordinating stakeholder engagement in ESBT and C4Y strategic planning processes, as part of the overall governance framework for accountable care
- Connecting with engagement activities to strengthen input, ensure feedback and provide a meaningful route for stakeholders to have strategic influence
- Helping to develop and champion a countywide approach to co-production in health and care

4. The group will:

- Discuss, agree and make evidenced based recommendation
- Expect its recommendations to be acted upon and to receive feedback on action taken
- Establish co-productive ways of working as relationships between group members develop and the role of the evolves

5. Membership
The group is made of up of stakeholders representing people and communities, including people using health and care services and their carers, staff from the statutory health and care organisations, and staff/volunteers from a range of partner organisations. The group is open to all and will strive to ensure a variety of communities are represented at any given time.

5.1 Core membership
There will be up to 30 members of the stakeholder group. 15 members will bring a community perspective, 13 will be representatives appointed from health and care organisations and 1 place is allocated to Healthwatch East Sussex. The remaining 2 places will be held and recruited to as/when when the group identifies the need for particular input.

Community members
There will be up to 15 representatives bringing a community perspective. They will be provide a focus around priorities/service areas, eg social isolation, mental health, carers.

They will ensure the needs of people with protected characteristics are picked up and addressed by the group including:

[3] This is a working title which the group itself may want to change and make more specific once it is set up

- Age
- Disability
- Gender reassignment
- Race
- Religion or belief
- Sex
- Sexual orientation

Individuals bringing a community perspective will:

- Be recruited every 2 years through an open and transparent requirement process. See the recruitment and selection process in Appendix C for more information
- Be required to demonstrate and fulfil a connection with communities and existing representative structures. For community representatives, it is likely that some of these connections will be fulfilled by individuals being involved in the community and voluntary sector
- Bring forward their expertise and knowledge in relation to this connection, but once on the group, they will be expected to engage in discussions to help shape the delivery of population outcomes
- Have a 3 year term of office. This can be extended at the group's discretion. If members' circumstances change during that time and they can no longer fulfil their community connection eg they no longer volunteer with a relevant community group, they will step down from the group and the vacancy will be advertised/recruited to.

Representatives from health and care organisations

We will seek one appointed representative from each of the following agencies:

- East Sussex County Council
- Eastbourne, Hailsham and Seaford Clinical Commissioning Group
- Hastings and Rother Clinical Commissioning Group
- High Weald Lewes and Havens Clinical Commissioning Group
- East Sussex Healthcare NHS Trust
- Sussex Partnership NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- South East Coast Ambulance NHS Trust
- District and Borough Housing
- Sussex Police
- East Sussex Fire & Rescue Service
- Healthwatch East Sussex
- Registered Care Association

These individuals will be senior decision makers involved in strategic planning for health and social care, and will have an equal role in contributing to the discussions of the group. There will also be an ESCC officer allocated to support the group and an independent facilitator.

The group comprises a maximum of 30 members with a quorum of 12 members of which there must be representation from the CCGs, an NHS provider, East Sussex County Council and 8 community stakeholder members.

Core members can send substitutes and deputies where they feel a colleague's expertise is required for a particular meeting. Regular attendance is required to enable the group to develop the necessary relationships and consistency in approach.

Membership of the group will be reviewed annually and gaps recruited to.

5.2 Other attendees

- Staff from specific ESBT and C4Y workstreams will be required to attend when the group is discussing areas that are their responsibility. If they are unable to attend in person, then they will nominate a suitable deputy to attend in their place.
- Other individuals will be invited to attend if specific specialist advice is required.
- Guest speakers will be invited when specific challenges or items of interest are being discussed.

See appendices for more information on:

- B Role and responsibilities of stakeholder group members
- C Recruitment and selection process
- D Principle and Values

6. Accountability

The group will nominate two community representatives onto the two groups which have responsibility for the whole system strategic overview and planning for health and social care:

- ESBT Strategic Commissioning Board
- C4Y Programme Board

The group will identify and arrange how it inputs to and connects with ESBT and C4Y workstreams/meetings/structures in accordance with its forward plan and priorities, e.g. it is likely to want to connect with the Planning and Design Groups in ESBT and Communities of Practices in C4Y.

7. Meeting arrangements, agenda setting and delegated powers

Meetings

- Meetings will take place every 3 months
- Where possible, they will be hosted in rotation by community members of the group (for which resources will be made available)
- Meetings will be led and facilitated by an independent facilitator
- Where possible, decision-making will be by consensus however it is likely the group may hold differences in opinions and views. Where consensus cannot be reached any differences will be recorded and reflected in the group's reports and actions
- Meetings will be supported by the Policy and Strategic Development Team in ASC&H who will provide a secretariat function for the group. Engagement officers from across health and care organisations will be involved in following up actions and supporting delivery
- Meeting papers will be circulated at least 10 days before the meeting and made as accessible as possible
- Meetings will be interactive and last no longer than 2-3 hours.

Agenda setting

- Agendas are set collaboratively and inform, and are informed by, whole system planning activity across ESBT and C4Y. The aim is to hold a shared vision and develop shared goals, with people who use services at the centre

- Agendas will make full use of existing intelligence gathered from engagement activities to ensure the focus of the group is shaped on communities' priorities
- Group members will discuss and agree an annual forward plan which prioritises agenda items and ensures all key strategic developments are included. At the end of each meeting the forward plan will be reviewed and any alterations agreed
- Agenda items will be invited as least annually via engagement activities in the system
- Adhoc suggestions will be considered on a needs basis and prioritised where necessary by the group
- Agendas will be realistic not overloaded, strategic and not operational, broad not narrow, and thematic

Sub-groups / tasks and finish groups

- The group may establish permanent or task and finish sub-groups
- Where it is more efficient for some tasks to be carried out by a small group of people, with the necessary capacity, skills and/or experience, this will be agreed by the group, well defined and documented
- Any sub-groups will report into the stakeholder group

8. Confidentiality

- Documents can be shared externally unless expressly stated as confidential or in draft form
- Members are required to respect confidentiality of specific topics discussed at the meeting as requested by other members

9. Resources and support

- Meeting, facilitation and other costs will be covered by Adult Social Care and Health
- Where further resources are required by the group, these will be identified and where possible covered from within existing resource or by seeking additional resource as necessary
- Support for group members from the community is detailed in Appendix E

10. Reporting and review

Reporting

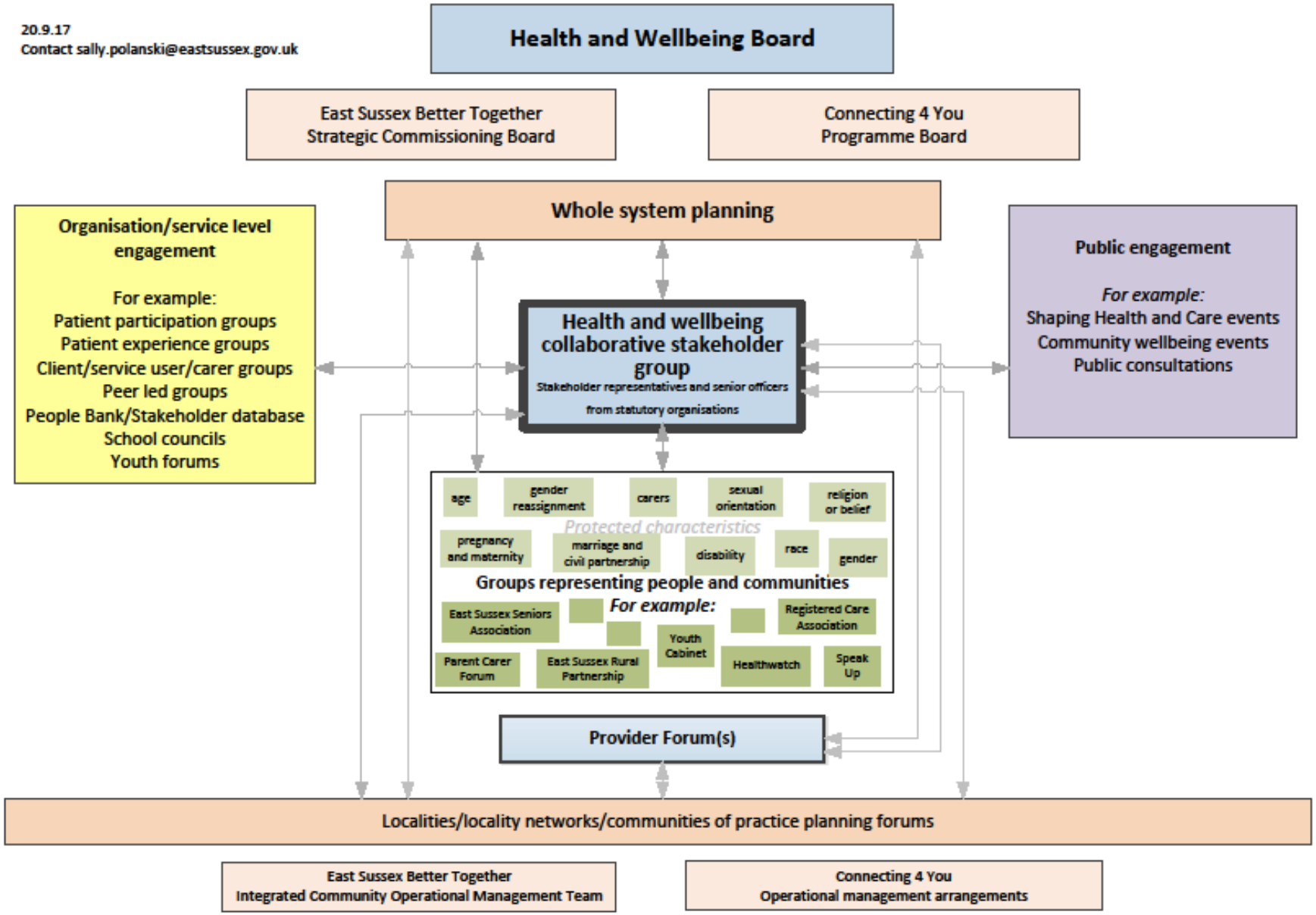
- The group will report in regularly to ESBT Strategic Commissioning Board and C4Y Programme Board
- A brief news update summarising the groups' achievements will be produced every 6 months and disseminated through engagement channels and networks

Review

- The group will review its Terms of Reference once it is set up and annually thereafter
- The group will agree a monitoring and evaluation framework for itself and its work
- In January and Sept 2018, the group will provide updates to the participants in the 7 July Partnerships and Planning workshop. This will provide feedback on how their suggestions are being used to develop the group.

Appendix A

20.9.17
Contact sally.polanski@eastsussex.gov.uk



Appendix B

Stakeholder Group member role description (community members and representatives of health and care organisations): what is expected of you?

1. Champion co-production

1.1 Ensure the perspectives of communities are able to be expressed across the system and are being gathered and used to influence any proposals and decisions that impact on service design, development and evaluation

1.2 Raise the profile and importance of patients, clients, carers and other stakeholder's views in influencing local health and care strategic developments, such as service planning, design and commissioning

1.3 Identify and confront challenges or barriers to co-production and seek to ensure they are overcome

1.4 Champion good practice in co-production at the service level within ESBT and C4Y

1.5 Be realistic about expectations and honest about influence – not everyone can be involved in all decisions and not all contributions can be taken on board

2 Connect with engagement activities

2.1 Receive information from engagement activities across the county to listen to concerns/ideas and reflect on experiences from the wider stakeholder community

2.2 Ensure the group hears about the experiences of people with protected characteristics and locality issues, and from small community groups that can sometimes be harder to reach

2.3 Help strengthen communication with stakeholders around ESBT and C4Y by sharing information and facilitating dialogue wherever possible

2.4 Work closely with engagement and communication leads across statutory organisations to join up activities and maximise synergies for joint work.

3 Inform strategic planning processes

3.1 Identify a forward workplan detailing the areas of focus for the group, linked with, but not limited to, strategic priorities in ESBT and C4Y

3.2 Develop, promote and scrutinise strategies, plans, projects and services

3.3 Provide strategic and evidence-based feedback on needs, concerns and interests

3.4 Identify areas of improvement or development and clear actions

3.5 Ensure follow-up of actions identified, working closely with engagement leads in statutory agencies who can support this

4 Promote the work of the group

4.1 Communicate feedback and achievements to the wider community including patients, clients and the public and across all stakeholders

4.2 Ensure all interested parties are kept informed about the work of the Group

5 Other requirements

5.1 Adhere to the group's values, policies and procedures, including good equalities practice

5.2 Engage in an individual review after 6 months trial period in the role

5.3 Give adequate notice of meeting absence or standing down from the role

5.4 Be prepared to be contacted outside of meetings when required

5.5 Be open-minded and have a flexible approach

Stakeholder group members' responsibilities		Approximate time commitment
1	Read papers, prepare for and attend regular meetings of stakeholder group	4-5 hours per meeting attended, usually 1/4ly
2	Prepare for and attend any other additional meetings	3-4 hours per quarter
3	Provide feedback to community/wider stakeholders by: • Reporting back after strategic meetings • Providing information on key issues as necessary • Presenting / facilitating at engagement events	1-2 hours per quarter
4	Participate in events and activities, to support the development of the shared views.	4-6 hours per quarter
5	Make efforts to consult and engage communities / colleagues on their views and communicate these at stakeholder group meetings[4]	2-4 hours per quarter
6	Participate in induction and training	6 hours

Skills, knowledge, abilities and experience required		Essential/desirable **community members** recruitment process
1	An understanding of communities and their needs. For community members, this will be gained through having some form of community connection (e.g. participant in community activities / linked to representative structures / employee of a voluntary organisation) A willingness to engage with a wide range of networks by attending events, networking, having two way dialogue and feedback with stakeholders, that will assist in developing a mandate and having an informed perspective	Essential
2	An ability to adhere to the values and principles in appendix D	Essential
3	A capacity to advocate and an ability to understand and express the difference between one's own / an organisational viewpoint and that of wider communities and their varied viewpoints	Essential
4	An understanding of the sensitivities of working across multiple sectors (public, private and voluntary) and an ability to develop partnership working, effective relationships, trust, challenge constructively and communicate in a mature / professional manner	Essential
5	An ability to keep up to speed on key agendas that affect the stakeholder group, including reading and digesting papers	Essential
6	Knowledge of health and care (services/strategies/policies/plans)	Desirable
7	Experience of representation and engagement	Desirable

[4] Stakeholder group members need to be able to represent the views of communities / their organisations

Health and care organisations' responsibilities: what you can expect from us

For the stakeholder group to work well, it will be supported in a range of ways by staff in health and care organisations.

- The group needs to :
    - Make full use of links to existing engagement mechanisms to access feedback and intelligence and to facilitate communication with wider stakeholders. This includes 'specialist' groups, forums, locality networks and service level 'customer satisfaction' and 'patient experience' activities. Information exchange will happen with these groups/activities in a variety of ways with and on an ongoing basis
    - Ensure that people with protected characteristics are adequately engaged and their needs considered, and challenge the system when they are not
    - Ensure that new engagement activities are established where necessary to address gaps in community voice
- The Shaping Health and Care events organised by ESCC and CCGs provide a system-wide public facing engagement opportunity. Engagement staff will ensure information flows between these events and the stakeholder group
- The stakeholder meeting process will be supported to enable group members to carry out their responsibilities:
    - Regular information bulletins on the work of the group will invite wider communities to get involved in activities and provide feedback on the work of the group. Proformas/templates will be produced which group members can use to easily cascade across their own networks, in particular those within the VCS which have reach into the community
    - Social media will be used to increase awareness of the group and opportunities to participate
    - Pre-meetings or discussions with individual group members/others will be set up as required to help prepare for meetings/particular agendas
    - Actions will be chased up by engagement officers across the health and care organisations to ensure they are completed
    - Members will receive clear and regular updates on actions and decisions made
- Other ways in which people in the community can communicate their ideas / priorities will be developed, eg
    - A suggestion box / social media equivalent will invite all groups to put forward comments which are analysed and considered
    - Online discussion forums/ app, webinars/live streams, Skype, Survey Monkey etc will be used to maximise opportunities for involvement
    - Contact points across the county will help navigate / sign-post anyone interested to the right point in the system to have a discussion
- A branding for the group will be developed to help with building awareness and trust

Appendix C

Stakeholder Group Recruitment Process

- Recruitment for the community stakeholder members of the group will take place every 2 years through an open application process or in light of a resignation
- Publicity advertising the opportunity to apply to join the group will be cascaded across as many networks as possible, and through targeted communication to seek to disseminate information to traditionally under-represented groups
- The application form will make clear requirements of the role and the selection criteria, to ensure the recruitment process is transparent and robust
- Guidance materials will include examples of the mandate which group members might have in terms of community connection and the types of scenarios they will be engaged in. There will be the opportunity to speak to someone to seek guidance and support in applying
- It will be made clear that support and development is available for individuals with less experience of similar representation and engagement activities
- Applications are sought from a range of representatives able to bring a community perspective on priorities/service areas, eg social isolation, mental health, carers. Applicants will also be sought who bring a perspective on the needs of people with protected characteristics, including:

    - Age
    - Disability
    - Gender reassignment
    - Race
    - Religion or belief
    - Sex
    - Sexual orientation

    Should a recruitment process not secure this representation of priority communities and their needs, then spaces on the group will be held back and further recruitment / co-option opportunities be explored to strengthen the make-up for group at the earliest opportunity.

Stakeholder Group Selection Process

Selection will be based on applicants' skills, knowledge, abilities and experience

Community stakeholder group members **Skills, knowledge, abilities and experience required**		**Essential/ desirable**	**Weighting**
1	An understanding of communities and their needs gained through having some kind of community connection (eg participant in community activities / linked to representative structures / employee of a voluntary organisation) A willingness to engage with a wide range of networks by attending events, networking, having two way dialogue and feedback with stakeholders, that will assist in developing a mandate and having an informed perspective	Essential	30%
2	An ability to adhere to the values and principles set out in appendix D	Essential	15%
3	A capacity to advocate and an ability to understand and express the difference between one's own / an organisational viewpoint and that of wider communities and their varied viewpoints	Essential	15%
4	An understanding of the sensitivities of working across multiple sectors (public, private and voluntary) and an ability to develop partnership working, effective relationships, trust, challenge constructively and communicate in a mature and professional manner	Essential	15%
5	An ability to keep up to speed on key agendas that affect the stakeholder group, including reading and digesting papers	Essential	10%
6	Knowledge of health and care (services/strategies/policies/plans)	Desirable	5%
7	Experience of representation and engagement	Desirable	5%

The selection process will involve:

- Scoring of the application forms received and shortlisting of suitable applicants
- Assessment of applications by a panel. The panel will have diverse representation from the community and in the first instance be drawn from those involved in the development process which lead to the group being set up, e.g. working group members and participants in the 7 July 2017 Planning and Partnerships workshop
- Informal interviews/meetings, providing an opportunity for discussion between potential group members and the above panel and/or other representatives from Adult Social Care and Health supporting the group.

Appendix D

Principles and values of the group

1. To adopt co-production as a way of working
2. To change behaviours, striving to involve people as early as possible
3. To create opportunities for people to participate so they can make things better for others
4. To recognise people's strengths and resilience, embrace diversity and value people's experiences. People who use services and with lived experience are more likely to be able to come up with solutions to the problems faced in their own lives
5. To listen and make sure that all voices are heard and acted upon
6. To empower people to have a say on what matters to them: participants will decide on meeting agendas and priorities
7. To be clear and transparent around what can and can't be influenced, at what level and who is responsible for making decisions. While we all aspire to everyone being equal in and to flatten hierarchy, we know that sometimes power dynamics will impact. The group will be honest about this, monitor power impacts and challenge where necessary
8. To be interested in all things: influencing plans, changing practice/culture and deciding how money is spent
9. To ensure participants can see if and how their views have influenced: to get timely feedback on our input and understand our impact
10. To be mindful of people's capacity to engage and address barriers to participation as much as possible. To use plain English and a wide variety of channels of communication to ensure information is co-ordinated, reaches people in the best way possible and is up to date
11. To view the success of the new approach as everyone's responsibility. To hold different views and be required to make difficult decisions
12. To expect to make mistakes, capture them and learn from them

To ensure these principles and values are embedded and making a difference in the system and the way the group works:

- They be included in induction, training and referenced in ongoing briefings of the group
- At the end of each meeting as a group and individually members will reflect on whether the principles and values are being followed
- The group will oversee implementation of such principles and values in the wider system as part of its remit in championing co-production

Appendix E

Support for stakeholder group members

- The contribution that volunteers make in helping to improve and develop services is valued. This is recognised through a Reward & Recognition Policy (R&R), which offers people the opportunity to claim expenses and reward payments appropriate to their level of involvement. Activities that qualify for a reward payment are paid at a rate of £20 per half day. This covers any preparation, printing of payment, travel time and follow-up work. R&R claims are paid on a monthly basis into people's bank accounts. Individual members of the Stakeholder Group will be eligible to claim both expenses and reward payments for attending the meetings. Before making a reward claim, it will be explained to group members that such a payment is considered as 'income' for tax purposes. Members of the group attending in a professional capacity on behalf of an organisation should claim expenses from their employer
- Regular briefings in writing/person will be provided as required. The focus of these and the need for information will be determined by group members, with support and advice from health and care organisations
- Learning and development opportunities, both generic for all members of the group and tailored to individual members' specific needs, will include:
    - Induction session and briefings on health and care (strategies, policies, plans, services)
    - Skills based training on effective partnership working. Content to be tailored by group members but potential focus on representation, influencing, and assertive communications
    - Facilitated team development for the group on its values and principles, ways of working, possible action learning set approach to this over time
    - Information briefing on health and care strategy
    - Information briefings and support from voluntary and community organisations able to offer a community / service user perspective easily
- Meetings will be well planned
- Independent facilitation, participative methodologies, accessible venue/times/language, and use of ground rules will ensure that everyone has the opportunity to participate. There will be a balance of formality, informality, creativity
- Specialist speakers will attend as required
- Buddying for members of the group will be provided where appropriate
- There will be feedback to group members on what difference their input has made

Benefits of being a member of the stakeholder group

- Increased knowledge of health and care in East Sussex
- Being involved in strategic planning processes and influencing decision making
- Gaining deeper understanding of a particular area of work
- Gaining new opportunities to network and build relationships
- Developing skills in representation, facilitation and giving presentations
- Developing communication skills (diplomacy, negotiation skills, assertiveness)
- Meeting like-minded people and building personal and social connections
- The opportunity to make a difference by:
    - Being part of change to improve local people's lives
    - Influencing agendas to ensure community priorities are addressed
    - Championing inclusion, diversity and the needs of under-represented groups
    - Helping to develop effective community engagement and service user participation

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- Identifying gaps and developing solutions
- Sharing good practice
- Building a sense of shared purpose, values and goals, enhancing collaboration and improving communication across different sectors
- Acting as a conduit for information sharing with wider communities

Appendix F

Ground Rules

To be determined by the group itself when it is set up

To include decision-making and managing conflicts of interest

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East Sussex Better Together (ESBT) Strategic Commissioning Board

Future work programme

Updated: August 2017

Agenda Item	*Objectives*	*Contact officer*
Standing items (these appear on each meeting's agenda)		
Questions from members of the public	Members of the public may submit written questions for the Board no later than five clear working days ahead of a meeting, stating the questioner's name and address. Written answers will be circulated at the meeting. The questions and answers will not be read out but the Chair may at their discretion allow the questioner one supplementary question to clarify the answer given.	Harvey Winder, Democratic Services Officer, ESCC
Strategic Commissioning Board Work Programme	To consider the proposed agenda items for future meetings of the ESBT Strategic Commissioning Board.	Claire Lee, Senior Democratic Services Adviser, ESCC
20 December 2017		
ESBT Alliance Progress Report	To consider an overview of progress for the 2017/18 year to date from the ESBT Alliance Governing Board, including an update on finance, performance and service developments. To consider any specific recommendations from the Governing Board.	Paula Gorvett, ESBT Programme Director
ESBT Outcomes Framework	To consider performance against the ESBT Outcomes Framework for quarter 2 of 2017/18.	Candice Miller, Policy Development Manager, ESCC
Strategic Investment Plan	To consider an update on the ESBT Strategic Investment Plan (SIP) 2017/18 and any specific recommendations from the ESBT Alliance Governing Board for adjustments to the SIP.	John O'Sullivan, Chief Finance Officer, EHS/H&R CCGs
ESBT Alliance New	To consider progress with further developing the ESBT Alliance and integrated strategic	Vicky Smith, ESBT

Agenda Item	*Objectives*	*Contact officer*
Model of Care	commissioning arrangements for 2018/19 onwards.	Accountable Care Strategic Development Manager
9 March 2018		
ESBT Alliance Progress Report	To consider an overview of progress in 2017/18 from the ESBT Alliance Governing Board, including an update on finance, performance and service developments. To consider any specific recommendations from the Governing Board.	Paula Gorvett, ESBT Programme Director
ESBT Outcomes Framework	To consider performance against the ESBT Outcomes Framework for quarter 3 of 2017/18.	Candice Miller, Policy Development Manager, ESCC
Strategic Investment Plan	To consider an update on the ESBT Strategic Investment Plan (SIP) 2017/18 and any specific recommendations from the ESBT Alliance Governing Board for adjustments to the SIP.	John O'Sullivan, Chief Finance Officer, EHS/H&R CCGs
ESBT Alliance New Model of Care	To consider progress with further developing the ESBT Alliance and integrated strategic commissioning arrangements for 2018/19 onwards.	Vicky Smith, ESBT Accountable Care Strategic Development Manager
Review of Strategic Commissioning Board	To review the Board's work during 2017/18 and consider its future role.	Vicky Smith, ESBT Accountable Care Strategic Development Manager (?TBC)
Annual report to Health and Wellbeing Board	To agree an annual report to the East Sussex Health and Wellbeing Board	Paula Gorvett, ESBT Programme Director (?TBC)

CCGs – Clinical Commissioning Groups

ESBT – East Sussex Better Together
ESCC – East Sussex County Council
EHS – Eastbourne, Hailsham and Seaford
H&R – Hastings and Rother

The East Sussex Better Together Alliance is a partnership of the following organisations
***NHS** Hastings and Rother Clinical Commissioning Group*
***NHS** Eastbourne, Hailsham and Seaford Clinical Commissioning Group*
*Sussex Partnership **NHS** Foundation Trust*
*East Sussex Healthcare **NHS** Trust*
East Sussex County Council

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